Making Evidence Matter in Canadian Health Policy

EDITED BY

NORALOU ROOS | KATHLEEN O'GRADY

SHANNON TURCZAK | CAMILLA TAPP | LINDSAY JOLIVET

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EvidenceNetwork.ca supports the use of evidence when reporting on health and health policy in the mainstream media. Specific points of view represented here are the individual author's and not those of EvidenceNetwork.ca. Let us know how we're doing: evidencenetwork@gmail.com

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Acknowledgements

The idea for EvidenceNetwork.ca was first discussed by Noralou Roos and Sharon Manson Singer over coffee one morning after lamenting how seldom nuanced research made it from academic journals to national broadsheets. The health policy landscape painted by the media did not often match that created by the research community, falling too often into the same old ideological private-public healthcare debates without much subtlety for what lies between. Did the fault lie with the researchers? With the media? Was it an unbridgeable divide?

The need to bring together Canada's talented journalists with Canada's talented health policy researchers became clear, and the need for tools to enable this better communication between two distinct professional fields with differing agendas became our goal. Thus, the Evidence Network of Canadian Health Policy, more commonly known as EvidenceNetwork.ca, was born.

What we didn't know at that time was how much work it would be for all of us (likely a good thing), nor how rewarding the outcome. EvidenceNetwork.ca would not be possible without the team of hardworking communicators, academics and journalists who have enabled us to further open the channels of communication — with mutual respect and understanding for both professions.

Our sincere thanks to our independent media advisory board who has guided us on the needs, challenges and nuts and bolts practices of media outlets across the country. Equally, we thank our network of more than 70 academic experts who have made a major commitment to go beyond academic publications and attempt to write for mainstream audiences. Here they have had critically important help from Kathleen O'Grady (QUOI Media Group) who strategizes with the authors about what audiences they want most to reach, what their key messages might look like, and the language and the style necessary to best reach their objectives and secure publication. It's been a learning experience for all of us.

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Our e-books — this is the second in our series — would not be possible without the numerous individuals who aided and contributed to this journey. A special thanks to Sarah Elaine Eaton of the University of Calgary for her advice on the e-publishing world, and to Richard Tapp for sharing his experiences with e-books in the classroom.

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And finally, many thanks to all of the media outlets who have worked with us and guided us along the path to make our project a success — with much still left to do.

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Introduction

There's simply no taking the politics out of the policy where Canadian healthcare is concerned — that's probably one truism everyone can agree on. Debate on healthcare reform has been nothing less than an ideological turf war for decades in this country, and neither side seems to hold a magical formula for breaking what has become a tiresome and tedious deadlock between "private" and "public" health camps. "Frozen in Time" is how public health reporter André Picard describes our health system in his 2012 Conference Board of Canada Scholar-In-Residence Lecture.[1] One could say the same of much of the healthcare debates played out across the country: frozen in time.

Yet, the evidence on what works in healthcare, from financing to funding and delivery models, only gets better and better as researchers examine and compare health systems around the world, and analyze data from decades of differing provincial and territorial models and pilot projects. Getting the evidence, as it turns out, has been the easy part — though it's always a work in progress, and academics have no shortage of things they'd still like to study. Getting that evidence to influence health policy has proved to be much more challenging.

Where's the impasse?

It has only been recently — the last decade or so — that those invested in health research have made significant inroads into policy circles, learning the needs of policy makers, and feeding their research into policy-relevant forums and discussions. But policy makers don't always get to make their favoured policies happen: that takes politics. And not all academics are interested in learning the political ropes and levers necessary to make change a reality — yet most would like to see their research reflected in practice, making a positive difference to how Canadians live their lives and interact with the healthcare system.

The media is an obvious path for communicating research from the siloed towers of the academy to influence mainstream conversations and influence political decision-making. Yet academics often have a dicey relationship with the media. "It's complicated," they might say. You don't have to go far to hear a story about an academic who feels he was misquoted or misrepresented in a media report. "Never again," is a common enough mantra.

Reporters, on the other hand, can tell you many anecdotes of academics who returned their calls weeks after a media request had been made, or provided unintelligible statements full of jargon or context-dependent research, or had unrealistic expectations about the scope and size of a mainstream media article. Neither side can seem to understand the other: "She demanded I show her the article before it appeared!" an incredulous journalist might complain — "He refused to let me see the article before it was published!" a skeptical academic might cry.

So we formed EvidenceNetwork.ca to help bridge the divide between those who work in the media and those who work in the academy. Experts on both sides have been invaluable in hosting workshops and exchanges, and bringing the two cultures together where they can understand each other's needs and demands. The timing couldn't be better, as the Canada Health Accord is set to expire, and the federal government has begun to change the way it both funds and interacts with the provinces and territories on the health file; as it turns out, injecting evidence into the public debate on healthcare has never been more important.

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1 The Path to Health Care Reform: Policy and Politics (The 2012 CIBC Scholar-in-Residence Lecture), p. 81

The Op-Ed model

At EvidenceNetwork.ca we've learned by trial and error — videos, press releases, webinars, infographics, eBooks, posters, social media — we've tried many ways to squeeze as much Canadian health policy evidence into the mainstream as possible. By far the most successful model we've employed has been encouraging and helping our academic experts write directly for the media in the form of commentaries, commonly known as Op-Eds. This allows the academic to provide the nuance and context for the research they wish to convey to the general public, but in the accessible voice, style, size and other strictures required of the media outlet in which they are published (See Appendix A).

In the first year (2011) we experimented with Op-Eds, we published more than 100 commentaries in the major media outlets alone. In our second year (2012), we published more than 265 Op-Eds in major media outlets (which includes the national broadsheets and all major city papers, as well as some key online-only sources). And in our most recent year (2013), we topped this again by publishing more than 375 Op-Eds in the major media outlets, with more than 580 hits in all media categories. In less than three years, we've had more than 1,200 media hits from commentaries alone (See Appendix B).

It hasn't all been a bed of roses. Some of our academic experts were already seasoned Op-Ed writers, but most were not, and had to learn, with editorial help, how to whittle decades worth of research down to 650 lonely little words. Most of our Op-Eds go through several drafts so that we make sure the commentary is able to convey the key messages in a manner as accessible as possible to reach the widest possible audience. And many of our Op-Eds also go through an informal "peer review" process, where other experts in the field subject the commentary to a reading to make sure the facts are represented in a fair, balanced and non-partisan manner. Opinions can be strong, but they need to be backed by the facts and with no outside agenda (commercial interests or political aspirations).

We use a professional media consultant (QUOI Media) and a media service, Troy Media, to make sure our commentaries are made available and "pushed out" to papers, large and small, across the country. We are sensitive to what papers will publish, and we help our academics to write strategically so that key messages are compelling, memorable and engaging. Op-Eds are the inverse of academic essays. Op-Eds are the inverse of academic essays — the thesis comes up top and the proof follows, not the other way around — so it has taken time for some of our academic writers to adjust and adhere to the format.

The results have been rewarding. We knew pushing healthcare policy evidence into the Op-Ed pages would generate results, we just weren't prepared for what forms they'd take. Some of our Op-Eds have resulted in requests for participation at political hearings and tribunals, some for visits to Ministry offices, and others have generated further media interest via radio or television interviews. Some have resulted in international exchanges of ideas with journalists, policy makers and academics working on health policy issues in other countries. We've also had letters from everyday Canadians, telling us about their health woes, their experiences — both positive and negative — with the healthcare system, and their ideas for change. In other words, reaching out beyond the academy has been more than worth the effort — and it simply makes us want to do more of it.

After the first year and a half of publishing commentaries in the mainstream press, we bundled them together in our first eBook, *Canadian Health Policy in the News* (2013). Now, in this volume, please find our second compendium of Op-Eds (materials published from October 2012 to October 2013). Like our first eBook, this second volume is a snapshot of a year in the health policy debates of our country. We've not altered the materials to reflect changes that may have taken place since the commentaries were written, but left them as they were published, to represent accurately the time in which they were written. Most Op-Eds were originally published in English, with some translated into French, where we had resources. A few were originally published in French, with English translations.

The book is organized into key themes that EvidenceNetwork.ca experts have agreed to tackle — areas where we feel the evidence is not yet being fairly represented in media, policy and/or political circles, and where we feel we can make a contribution. **Sustainability** documents the challenges of affording the healthcare system Canadians want and need, and explores the way our health system gives us a competitive advantage internationally, and fleshes out optimized funding formulas that work for all regions of the country. **Costs and Spending** looks at remuneration systems and how they may differently incentivize those who work in the health domain in Canada, the relationship between health care dollars and healthcare quality, and how our health system contributes to a more equal society. This section highlights why healthcare costs so much and what parts of the system are eating up our healthcare dollars.

Pharmaceutical Policy looks at patent processes and access to affordable, quality medications, at the over-prescription of certain medications, and the relationship of pharmaceutical firms to health research, education and marketing. This section highlights the research suggesting why a national pharmacare program makes sense, and the health cost of unaffordable pharmaceutical drugs, as well as the variations of drug programs across the country — what's working and what's not. **Private, For-Profit** examines the evidence comparing private-for-profit delivery of healthcare with public delivery, and the problems which arise in those sectors that largely aren't covered by our public healthcare system, such as prescription glasses or dental care.

Health is More than Healthcare details the important social determinants of health, such as the relationship between poverty and good health, home and food security, income distribution, chronic stress, discrimination in the health system and healthy parenting. **Aging Population** looks at the impact of our aging society on our health system, and does some myth busting on the so-called "aging tsunami," as well examining the need for pension reform in Canada, and what path that might take. **Mental Health**, a new topic of focus for EvidenceNetwork.ca this year, examines the relationship of chronic stress and health status. More will be done in this area by our experts in the coming months — stay tuned to our website. Also new is the section on **Obesity**, which looks at why traditional methods for combating the obesity epidemic have failed, and what works for those trying to change their lifestyle to healthier habits. We examine possible policy levers to help tackle obesity and look at weight-based discrimination and what can be done about it. Finally, in our **Appendix A and B**, we provide more details about the EvidenceNetwork.ca project for those who wish to know more about us in detail.

We hope this second snapshot of a year in Canadian health policy will be useful to those trying to improve our healthcare system for the countless Canadians who are proud of what we've achieved, but who know we can do better still.

In his 2012 Conference Board of Canada lecture, André Picard also said, "The most powerful force in Canadian health care is inertia" — and he couldn't have been more right.[2] We hope our little project — infusing more evidence into mainstream media debates about the Canadian healthcare system — will do a small part in helping to dislodge our health system out of the status quo, from inertia to healthy reform. It's not enough to cry "public" or "private" anymore. Canadians deserve better, they deserve evidence — in all of its nuance, complexity and contingency. Canadians know our healthcare system is a work in progress, but we also know it is worth the effort, and that to make it work, it has to be perpetually stamped with our needs, wants and truths. Putting the evidence out there for all to share gets us part of the way there.

2 The Path to Health Care Reform: Policy and Politics (The 2012 CIBC Scholar-in-Residence Lecture), p. 100

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Chapter 1: Sustainability

Is the Canadian healthcare delivery system a Ponzi scheme?

Robert L. Brown

Academics and policy wonks who wish to privatize many benefit delivery systems in Canada have a new media savvy salvo now aimed at the Canadian healthcare system. They argue that since this system is not pre-funded, then it is a Ponzi scheme with costs being passed to the next generation that are not sustainable.

According to Wikipedia, a "Ponzi scheme is a fraudulent investment operation that…is destined to collapse."

Is our healthcare system a Ponzi scheme?

It's true that our healthcare system is not pre-funded. Each year we have to find tax dollars to cover the benefit expenditures for that year. But all taxed-based benefit systems have unfunded future commitments. This includes all schools and all infrastructure, like highways. We don't hear the same fears about their being "unfunded."

What makes healthcare a more appropriate target is that the aging of the baby boom will put upward pressure on healthcare costs since they rise with age. More accurately, these costs peak in the last few months of life. So, as the baby boomers approach their time of death, healthcare costs will experience upward pressure.

Bill Robson of the C. D. Howe Institute estimates that the present value of this "implicit liability" of promised public healthcare spending under the pay-as-you-go funding model by 2040 could be as much as $1.4 trillion (the value of the unfunded portion of future healthcare costs).

The impact of population aging on healthcare has been researched extensively (almost to death). Population aging, by itself, will increase healthcare costs by about one percent per annum. If today healthcare costs $6,000 per capita, then 10 years from now, that will rise to $6,630, purely because of population aging. What percentage this will be of GDP will depend on how rapidly GDP is growing, but with any growth, the overall impact will be less than one percent per annum. Any rise in costs in excess of those projections will have other causes (e.g., over servicing).

Thus, if we are worried about healthcare costs, it is this modest added cost gap (because of the aging of the baby boom) that should be our focus rather than fully pre-funding the system.

Many commentators point to the CPP as a success story with respect to adjusting to the aging baby boom. In the early years, the CPP ran on a pay-as-you-go basis. Contribution cheques came in in the morning and benefit cheques went out in the afternoon. Assets were not growing. But in 1996, the plan was significantly amended with contribution rates rising from six percent in 1997 to 9.9 percent in 2003. The plan now has assets of around $160 billion.

But, it is not fully funded. The liability of the CPP is around $900 billion, making the plan approximately 17 percent funded. That is, total assets are about one sixth of total liabilities. What is important, however, is that the plan is sustainable for the next 75 years with the current contribution rate of 9.9 percent.

Given the data above, the focus of our concerns for healthcare financing should be the temporary added costs of the baby boom. If we decide to have partial pre-funding to manage the baby boom hump, then we need to move quickly. For example, shifting the eligibility age for OAS from age 65 to age 67 was delayed until 2023. Thus anyone born before 1958 faces no impact at all, which is the majority of the baby boom.

One mitigating factor in this saga is the improving life expectancy of Canadians. Given that the biggest expenditure on healthcare is just before death, improving life expectancy (delaying the time of death) saves the healthcare system money. In a pay-as-you-go system, any costs delayed are actually costs saved.

So, while there are some real concerns for the sustainability of our health system, they are not as overwhelming as portrayed by some commentators, whose real agenda may be the privatization of our health system.

Clearly, the Canadian healthcare delivery system is NOT a Ponzi scheme. It is not fraudulent and it is not destined to collapse. And, full pre-funding should not be the preferred policy solution.

Robert L. Brown is an expert adviser with EvidenceNetwork.ca and a fellow with the Canadian Institute of Actuaries. He was a professor of Actuarial Science at the University of Waterloo for 39 years and a past president of the Canadian Institute of Actuaries.

(December 2012)

A version of this commentary appeared in *the Globe and Mail*, *the Vancouver Sun* and *the Waterloo Region Record.*

It’s time to view public healthcare as an economic asset

Cy Frank

The road to reviving Canada’s sluggish productivity may lead straight to an emergency department — or an operating room — or an immunization clinic.

Sound implausible? Only if you consider public healthcare from the tired and usual point of view — which is that it is a consumption good, sucking ever-larger amounts of money out of a shrinking taxpayer pocket. Strike another commission, Canada.

But if you can accept the notion that public healthcare, if optimized, could be an investment good yielding future wealth as opposed to a consumption good using up current wealth and resources, the road to reversing our productivity slide seems suddenly to be freshly paved.

Take a pass on the commission, Canada. Take a progressive look at public healthcare.

Healthcare is a form of human capital. Considered in the broadest sense, healthcare encompasses public education and prevention services as well as the delivery of care when illness strikes. As such, it is actually one of society’s critical means of keeping our population productive.

The correlation between health and productivity has been illustrated in different ways. The Canadian Institutes of Health Research estimated the outbreak of severe acute respiratory syndrome (SARS)

in 2003 took $3.6 billion U.S. out of Canada's GDP and one percent off its economic growth. Imagine the consequences — both economic and human — had SARS gone unchecked.

More recently, the Fraser Institute estimated that work-time productivity losses due to long waits at hospitals and to see specialists cost the Canadian economy $1.08 billion Canadian in 2011. The cost tripled to $3.29 billion when time outside of the working period was included.

These examples are at the system level. Think of the value impacts, as well, at the individual level: having a worn out joint replaced or having a heart attack treated can allow people to remain productive for years beyond what would have been their original "shelf life."

Canadians can't afford productivity losses. We've had two decades of sluggish productivity growth. The Conference Board of Canada reported last year that our productivity level has fallen to 80 percent of the U.S. level from a high of 90 percent in the mid-1980s.

If we can agree that efficient healthcare is an enabler of productivity and that productivity is key to wealth, the next steps should be easy: first, view public healthcare as a significant driver of our economy; next, consider our expenditures in healthcare as a potential investment yielding future wealth; finally, manage those investments strategically to ensure we get maximal value for our money.

The latter will take much effort given the inefficiencies in public healthcare in Canada.

This would be a cathartic and defining shift for Canadians, who have been locked in a philosophical debate over public vs. private healthcare. In fact, the core issue should be how to get maximal value for all of our health dollars. This is not about spending more or spending less; it's about investing for value.

"Show me the value" should be the new mantra in public healthcare. Indeed, it seems to be gaining traction.

The premiers last year created a Working Group on Healthcare Innovation to "enhance patient care and improve value for taxpayers." Ontario's government this year announced an action plan that will shift funding to "where we get the best value."

This summer, Alberta's healthcare agency, Alberta Health Services, launched its first group of Strategic Clinical Networks, a new concept in public healthcare in Canada. They will bring together medical practitioners, patients, business people, researchers and others in teams that conceive and carry out projects aimed at improving healthcare services to achieve better outcomes for all Albertans and generating measurable value for the public money invested.

We appear to be finally moving away from viewing public healthcare as an economic burden.

The new view emerging is that of an extremely valuable asset — an asset that is a big part of the economy and can be managed better and exploited more fully by drawing on the bright minds, unique perspectives and special skills that exist in the medical, business, social and academic communities.

As this asset strengthens, productivity will continue to grow and the important correlation between strategic healthcare investments and our economy will become abundantly clear.

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How universal pharmacare might just save our healthcare system

Canadians over-pay for pharmaceutical drugs by $8 billion every year

STEVE MORGAN

When the topic of universal drug coverage comes up in this country, the debate often runs aground on the question of cost. In an environment of government austerity, few seem willing to embrace the idea of a new, national government program.

But a single-payer, universal system would not bankrupt the healthcare system. Quite the opposite, in fact; we're paying too much for prescription drugs now, and a single-payer system might just be what would save our healthcare system because it would be cheaper — a lot cheaper.

The first way a single-payer system for prescription drugs lowers total costs for medicines is through reduced administration costs. Drug plans spend a considerable amount of money on administration. This includes a range of tasks, such as negotiating contracts, identifying beneficiaries, collecting revenues, processing claims, providing information, managing risk and marketing.

A 2010 report by the World Health Organization estimates that administrative costs for private health insurance are on the order of about 15 percent of spending in wealthy countries, including

Canada. The same report estimates that administrative costs for public health insurance systems in wealthy countries are only five percent of spending — public estimates for Canada are even lower, about two percent.

Administrative costs differ because, when there are multiple insurers in a system that must compete with each other, most administrative costs are duplicated by every insurer. For-profit insurers must also provide their shareholders a return on investment. In contrast, there is no duplication of administrative costs in a single-payer system and some administrative costs — such as marketing — are eliminated altogether.

The additional costs of administration and profits required in a multi-payer system add up substantially. Given that about $10 billion worth of prescription drugs are financed through private insurance in Canada, a single-payer system could reduce administrative costs in the system by approximately $1 billion per year.

A multi-payer system also reduces the bargaining power of insurers and thereby increases the costs of drugs for Canadians. This is particularly important now that drug prices are increasingly being determined through the negotiation of confidential rebates paid directly by manufacturers to insurers.

An insurer acting as a single payer on behalf of an entire province or country has considerable purchasing power. In effect, manufacturers will give single-payer systems their best available prices because the rewards of accessing the entire market for a province or country are great — especially when the alternative is to lose the entire market.

Research has shown that the single-payer for pharmaceuticals in New Zealand negotiates brand-name drug prices that are roughly 40 percent lower than Canadian prices. Even the United Kingdom, with a high concentration of pharmaceutical sector investment, pays 18 percent less than Canada for patented drugs. If we had U.K. prices for those drugs here, we would save $3 billion per year.

The discounts single-payers can achieve on generic drug prices can be even bigger.

Canadian provinces recently announced that they were working together to limit the prices of six top-selling generic drugs to just 18 percent of brand name prices in Canada. This would save governments approximately $100 million. That sounds impressive — but the prices agreed upon by governments here are about 10 times higher than prices single-payer systems achieve in other countries. Savings on that order applied to all generic drugs would reduce drug costs in Canada by $4 billion per year.

A single-payer pharmacare system could save Canada $8 billion per year through lower drug prices and improved administrative efficiency. But implementing a system that would deliver better drug coverage at lower cost will nevertheless require political will. It would be the biggest health reform of a generation and likely would meet strong resistance from those whose incomes are dependent on excess spending in our current system.

Recently over 200 policy-makers, patient advocates, health professionals, manufacturers and insurers came together for PharmaCare 2020, a national symposium to promote clarity about the future of prescription drug coverage in Canada. This conference set a dialogue in motion that has been a long time coming.

It's pretty clear: We need to start working together to fix our broken health system. We can't afford

not to.

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How our health system contributes to a more equal society

New study shows publicly funded healthcare also a form of income redistribution

MICHAEL WOLFSON

The Canadian Institute of Health Information (CIHI) recently released a new study on the impacts of Canada's publicly funded healthcare on income inequality. Overall, healthcare spending amounted to over $200 billion in 2012. Of this amount, over $140 billion was financed by federal and provincial tax revenues.

While these grand totals are published every year, the latest CIHI study is unique in that it breaks down both healthcare spending and the taxes used to finance it by income groups. With the trend toward growing income inequality, this study shows the powerful equalizing impact of publicly financed healthcare in Canada.

Of course in part, this redistribution should not be surprising. Canadians tend to have their highest incomes in middle age, so this is the stage of life when tax payments are also highest, while their healthcare needs are lower. Healthcare use is highest at older ages, when incomes and therefore taxes paid are lower. As a result, a considerable amount of the income redistribution embodied in the publicly financed portion of our healthcare is simply redistribution across age groups. In this regard, healthcare has some parallels with public pensions — we pay taxes and make contributions during

working ages, and draw benefits when we are older.

From another perspective, however, this redistribution may be overstated. Most of us will pass through both middle age and old age. So looking over a longer time frame than a single year, some of the redistribution embodied in the publicly financed portion of our healthcare is from ourselves when we are young or middle aged to ourselves when we are older.

The new CIHI study is novel because it includes this kind of lifetime perspective. For example, assuming the patterns we observe in the 2011 data were held fixed over our lifetimes, Canadians could expect to use an average of $220,000 of publicly financed healthcare.

What's worth noting is that the top income group — quintile or fifth of the population — has a life expectancy about five years longer than the bottom fifth. At the same time, those in the bottom fifth of incomes not only have shorter lifetimes, they also have more illness during their years of life. The CIHI study takes account of both the fact that higher incomes are associated with significantly longer lifetimes, and that higher incomes are associated with lower rates of disease.

Using this unique lifetime perspective, the CIHI study estimates that the top fifth receives 6.6 times as much income before income tax as the bottom fifth. Switching to disposable income, total income less income and payroll taxes, the gap falls to 5.1 times. And when the value of publicly financed healthcare is added, the gap between the top and bottom fifths, again using lifetime income, falls to 4.3 times.

The bottom line: even after netting out the age factors and the differences in life expectancy, publicly financed healthcare in Canada plays an income redistribution role as important as income taxes.

One important limitation of the CIHI study is that it does not look into how much health we are getting for our healthcare dollars. Unfortunately, there is plentiful fragmentary evidence that many of the dollars spent on healthcare have no health benefits whatsoever.

Another limitation is that the CIHI analysis draws on only a snapshot of data from 2011. As a result, it is unable to consider a number of important trends. One of these is federal-provincial fiscal transfers. Through programs like Equalization and the Canada Health Transfer, the federal government provided over $50 billion to the provinces in 2011, much of which was used by the provinces to help pay for hospitals, physicians, drugs and other healthcare costs.

Recent federal budget changes, though, have shifted the trend line, so that these fiscal transfers will grow more slowly. At the provincial level, tackling budgetary deficits is placing further downward pressure on the growth of spending for healthcare. As a result, the amount of income redistribution occurring via publicly financed healthcare could well decline over coming years.

The CIHI study adds important new information we can use to track these changes; the analysis should be expanded. With the broad trend toward increasing inequality in market incomes, the role of the public sector, through both progressive taxation and providing essential services like healthcare, is fundamental to maintaining a more equitable, healthy and convivial society.

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Hospital funding needs strings attached

It's time to track health outcomes and patient satisfaction

JASON M. SUTHERLAND AND NADYA REPIN

As provincial government revenues stagnate with the sluggish economy, provinces are turning their eye to hospitals as a very obvious target for reductions in spending growth. Provinces spend more than $60 billion a year on hospitals, which is more than they spend on many of their entire ministries.

Right now, most of this money flows to hospitals with few strings attached. Changes are underway to hospital funding pathways, however, to try and ensure that we get good value for that money.

The most recent data from the Canadian Institute for Health Information (CIHI) points to marked variation between hospitals in what this money buys. For example, a hospitalization for a hip replacement in one region can cost in excess of 50 percent more than other hospitals in the same region.

The public should care about this, since large differences in spending between hospitals for the same type of care imply that there is potential for governments to cut spending. If hospital A can do hip replacements for $5,000 per patient why are we paying hospital B $8,000 per patient? If governments can find ways to bring hospital B's costs closer to $5,000, the hospital has become more ef-

ficient and government spends less.

Every year, provinces give hospitals a fixed percentage increase to their budget from the previous year. This across-the-board increase, similar to a cost of living increase, is intended to reflect increasing input costs, such as wage increases and new technologies and drugs. Over the past half-decade, these annual increases have been in the neighbourhood of five percent.

This type of budgeting and incentive structure rewards all hospitals with new funding equally. Perpetuating across-the-board increases provides little motivation for inefficient hospitals to change the way they operate.

Ontario and British Columbia are starting to change the way they fund hospitals. For the past few years, both provinces have directed hundreds of millions of dollars to hospitals as an incentive to perform more surgeries by tying funding to a fixed price per surgery. Hospitals that can perform surgeries at or below that price will generate free cash flow. Hospitals whose costs per surgery are higher quickly realize that they are receiving smaller increases than their more cost-efficient peers.

Some hospitals can't compete on cost-efficiency alone. Hospital spending data shows that it costs more to operate hospitals in small and isolated communities than in urban centres.

Ontario and British Columbia are hoping their new hospital funding initiatives won't close hospitals or undermine quality, but will instead put financial pressure on inefficient hospitals to change their management practices.

It's not all about saving money.

Every opportunity to improve the safety and quality of hospital care should be seized. Government regulations can be vigilantly monitored to ensure hospitals are meeting acceptable standards of safety. Meeting such standards could also be tied to new hospital funding.

Another idea is to measure quality from the perspective of the patient. The experiences of patients at the hospital and changes in their quality of life after surgery should be tracked. Too often, provinces are choosing hip and knee replacements without considering other surgeries and procedures.

The value we get for the money we spend on hospital care can be improved by changing the way we spend that money. Perpetually distributing lump sums to hospitals with few strings attached can no longer be excused in the current economic climate. While change won't be easy, it's good that Ontario and B.C. are leading the way. Other provinces will follow.

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Re-tooling the healthcare system

Physician networks offer a way forward

THÉRÈSE STUKEL AND DAVID HENRY

As Canadians, we take justifiable pride in our healthcare system with its long record of equitable coverage for most important services. If you become acutely ill and you live close to a major centre you will receive care that is as good as anywhere in the world.

But how good is our healthcare overall compared with the rest of the world?

In 2010, the New York based Commonwealth Fund survey found that Canada ranked near the bottom in a seven-country comparison of several measures, including access, safety, equity and efficiency. A recent report in *The Lancet* compared burden of disease statistics in 19 OECD countries. In terms of life expectancy at birth, and years of life lost, Canada slipped from second to seventh and from fourth to 10th position, respectively, between 1990 and 2010, although all measures improved over time.

So what is the cause of Canada's uncompetitive performance in health and healthcare and should it make us reconsider the way that we deliver services?

One major challenge is coordinating the care of chronic disease. Heart disease, stroke, chronic

obstructive pulmonary disease and diabetes are leading causes of death in Canada. They affect more than one in three Canadians, have a major effect on health and quality of life and account for more than half of provincial healthcare spending. However, the current structure and payment system, with heavy investment in hospitals, is designed for acute episodic care and copes poorly with the needs of chronic disease patients.

Fragmentation and poor coordination result in serious gaps in quality of care. Chronic disease management programs require a multidisciplinary approach designed to encourage adherence to medications and lifestyle changes, and promote patient self-management. Such programs can reduce complications, avoid costly readmissions to the hospital, and improve survival and quality of life.

Achieving these goals is difficult, as it requires coordination of care through teams of multidisciplinary professionals across different healthcare sectors over a sustained period of time. Most provinces have deployed a range of primary care models to promote continuity and comprehensiveness of care, but these models have not integrated specialists and hospitals into care management teams.

So how can Canadian policy-makers implement more coordinated care? In a study published recently in *Open Medicine*, we argue that virtual multispecialty networks may be a useful model of care delivery.

Virtual networks are informal, self-organizing systems consisting of primary care physicians, specialists, interdisciplinary health providers and the hospitals where their patients are admitted. We identified and characterized 78 multidisciplinary physician networks in Ontario. In the absence of any formal coordinating structure, they developed naturally through long-standing referral patterns, sharing of information, and admission of patients to the same hospitals.

The networks are large and stable, and each includes several primary care groups, many specialists and at least one hospital, all organized around a common patient population.

Physicians in such networks are associated by virtue of sharing care for common patients, admitting patients to the same hospitals, and sharing important resources that affect their patients' outcomes. These networks are not formally constituted organizations and providers are typically unaware that they are part of one. Consequently, they lack advanced processes for sharing information and coordinating care. Yet strengthening these existing links may be an efficient way to build networks of providers that already have shared patients and long-standing relationships.

Self-organizing multidisciplinary networks could form the basis of "systems of care" that collectively serve their large panels of patients. They are sufficiently large to provide a range of healthcare services, implement system improvements and be held accountable for results.

Investments in better patient information sharing systems, communication and collaboration protocols and common performance metrics, combined with appropriate incentive payment structures that reward coordinated care, could help catalyze significant advances in care for patients with chronic disease. Importantly, they could also work in collaboration with public health units to deliver disease prevention programs.

Formal constitution of multispecialty physician groups around existing patterns of patient flow could serve as a model for "accountable care systems" that aim to facilitate coordination of care at a local level for high needs patients, as it is aligned with a systems-minded approach to providing long-term chronic disease care and prevention.

There's one thing of which we are certain: maintaining the status quo is not sufficient for Canadians to retain pride in our healthcare system. The time for reform is now.

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Restoring the purpose of the Canada Health Transfer

Alberta the only province to benefit from the new funding formula

Gregory P. Marchildon and Haizhen Mou

The new Parliamentary Budget Officer, Jean-Denis Frechette, recently announced that Ottawa's reform of the Canada Health Transfer (CHT) and spending cuts make federal finances sustainable for the long-term — but possibly at the expense of the provinces. Capping the CHT to the rate of economic growth, it appears, will make provincial finances less sustainable.

But this is only one aspect of CHT reform that could negatively impact the provinces. The second, less visible CHT reform — the change to a pure per capita funding formula — will have an even more negative impact on the ability of most provinces to finance necessary healthcare.

In the federal budget of 2007, the Harper government announced that the CHT would be allocated on a strict equal per capita basis beginning in 2014. What this means is that each province will receive a CHT amount according to the size of its population, regardless of the income, demographic, geographic or other conditions of the province. This is significantly different from the current formula, which allocates CHT based on both the population share and the income level of the provinces.

Although the new CHT formula seems balanced and fair on the surface, it will, in fact, make it much

more difficult for some provinces to afford necessary health services given their unavoidably higher cost structures for medicare. Less populous provinces with relatively larger and more isolated rural and remote populations, for example, have to spend more to deliver a similar basket of services relative to more densely populated provinces. Similarly, provinces with a larger proportion of older residents also face higher healthcare costs.

The "Big Three" federal transfers of monies to the provinces presently — the CHT, the Canada Social Transfer (CST), and Equalization — were established to fulfil the national objective of ensuring that core health and social services are made available to all Canadians, an objective that we have entrenched in the Charter of Rights and Freedoms. In theory, the CHT should uphold the five criteria of the Canada Health Act: public administration, comprehensiveness, universality, portability and accessibility of health services — thereby encouraging a sense of common citizenship even if there are differences in how medicare is managed and delivered across the provinces.

When combined with a lack of desire to enforce even the minimal criteria under the Canada Health Act, the new formula is money for nothing. In fact, the new formula will take money away from most provinces while delivering an enormous windfall to Alberta.

Based on estimates for 2014–15, Alberta will receive $954 million more under the new formula than under the current formula — $235 for every man, woman and child in the province. Every other province will lose money as follows: Ontario, $335 million; British Columbia, $272 million; Quebec, $196 million; Newfoundland, $54 million; Manitoba, $31 million; Saskatchewan, $26 million; Nova Scotia, $23 million; New Brunswick, $18 million; and Prince Edward Island, $3 million.

In other words, the government of Alberta is the only winner — a reward perhaps for already running the most expensive provincial health system in Canada?

To remedy this, we propose an alternative formula that adjusts for two healthcare cost drivers over which provincial governments have no control: demographic aging and geographic dispersion. Those provinces and territories with both a more highly dispersed and an older population would receive more CHT. Think about Labrador as well as the northern and rural areas of Manitoba and Saskatchewan. Those provinces with either an extremely young demographic (Alberta) or a highly urbanized population (Ontario) would receive less.

Altering the CHT in this way would assist provinces facing unavoidably higher health costs to continue to provide medicare services of roughly comparable quality under the five criteria of the Canada Health Act. In other words, the CHT would again serve a national policy purpose, not automatically dish out money based blindly on a population count.

Canadians want to know that their citizenship means something more than being the resident of an individual province. They want to know that they will have access to needed medical services without financial barriers wherever they live in the country. It is time to revisit the original purpose of the CHT.

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Redéfinir l'objectif du Transfert canadien en matière de santé

L'Alberta : la seule province favorisée par la nouvelle formule de financement

Gregory P. Marchildon et Haizhen Mou

Le nouveau Directeur parlementaire du budget, Jean-Denis Fréchette, a récemment annoncé que la réforme du Transfert canadien en matière de santé (TCS) d'Ottawa et les réductions de dépenses assainissent les finances fédérales, à long terme. Toutefois, ce sont peut-être les provinces qui en feront les frais, puisque le plafonnement du TCS au taux de croissance économique risque de réduire la viabilité des finances provinciales.

Par ailleurs, ce n'est là qu'un seul aspect du TCS qui pourrait entraîner des effets néfastes sur les provinces. Le deuxième aspect, moins visible, est l'adoption d'une formule de financement purement per capita, laquelle portera un coup encore plus dur à la capacité de la vaste majorité des provinces à financer les soins de santé essentiels.

Dans le budget fédéral de 2007, le gouvernement Harper a annoncé que les fonds de TCS seraient alloués strictement à montant égal par habitant, et ce à compter de 2014. Cela signifie que chaque province recevra un montant de TCS selon la taille de sa population, peu importe le revenu et les conditions démographiques, géographiques ou autres vécues dans la province. Cette formule diffère de façon significative de la formule actuelle qui alloue des fonds du TCS selon l'importance de la

population et les revenus des provinces.

La nouvelle formule de TCS semble, à prime abord, juste et équilibrée, mais dans les faits, les provinces auront beaucoup plus de difficulté à offrir des services de santé, vu les coûts inévitablement élevés de l'assurance-maladie. Par exemple, les provinces moins peuplées, dotées de grandes populations plus isolées vivant en régions rurales et éloignées, doivent dépenser plus d'argent pour livrer un panier de services comparable à celui offert dans les provinces plus populeuses. De même, les provinces dotées d'une plus grande population âgée font face à des coûts supérieurs.

Les « trois grands » transferts de fonds fédéraux aux provinces présentement en place, soit le TCS, le Transfert canadien en matière de programmes sociaux (TCPS) et la péréquation, ont été créés pour assurer la prestation de soins de santé et de services sociaux essentiels à tous les Canadiens et les Canadiennes, un objectif national que nous avons enchâssé dans la Charte canadienne des droits et libertés. En théorie, le TCS doit soutenir les cinq principes énoncés dans la Loi canadienne sur la santé : la gestion publique, l'intégralité, l'universalité, la transférabilité et l'accessibilité des services de santé. Ces principes favorisent un sentiment de citoyenneté commune, même si le régime d'assurance-maladie et la façon de gérer et de livrer les soins diffèrent d'une province à l'autre.

Combinée à un manque de volonté de respecter même les principes minimaux dictés par la Loi canadienne sur la santé, la nouvelle formule propose de l'argent sans aucune contrepartie. En fait, cette formule désargentera la vaste majorité des provinces tout en acheminant une véritable manne vers l'Alberta. Selon des prévisions pour 2014–2015, cette province recevra 954 millions $ de plus sous la nouvelle formule, soit 235 $ supplémentaires pour chaque homme, femme et enfant sur son territoire. Les autres provinces perdront les sommes suivantes : l'Ontario, 335 millions $; la Colombie-Britannique, 272 millions $; le Québec, 196 millions $; Terre-Neuve, 54 millions $; le Manitoba, 31 millions $; la Saskatchewan, 26 millions $; la Nouvelle-Écosse, 23 millions $; le Nouveau-Brunswick, 18 millions $; et l'Île-du-Prince-Édouard, 3 millions $.

Bref, le gouvernement de l'Alberta est le seul gagnant. Serait-ce une récompense pour avoir mis en place le système de santé provincial le plus coûteux au Canada?

Pour remédier à cette situation, nous proposons une formule de rechange. Celle-ci prévoit des ajustements selon deux facteurs qui influencent le coût des soins : le vieillissement démographique et la dispersion géographique. Les provinces et les territoires dont la population est à la fois plus dispersée et plus âgée bénéficieraient de transferts plus élevés. Pensons au Labrador et aussi aux régions boréales et rurales du Manitoba et de la Saskatchewan. Les provinces dont la population est extrêmement jeune (Alberta) ou très urbanisée (Ontario) recevraient moins d'argent.

Si les sommes de TCS étaient réparties de cette façon, les provinces aux prises avec des frais de santé inévitablement plus élevés pourraient continuer à fournir des services de santé dont la qualité respecterait à peu près les cinq principes énoncés dans la Loi canadienne sur la santé. En d'autres termes, le TCS servirait à nouveau les objectifs d'une politique nationale et les fonds ne seraient pas aveuglément distribués en fonction d'un simple décompte démographique.

Les Canadiennes et les Canadiens veulent pouvoir compter sur le fait que leur citoyenneté leur procure plus qu'un droit de résider dans une province et qu'ils peuvent accéder aux services médicaux dont ils ont besoin, sans entraves financières, peu importe où ils élisent domicile. Le temps est venu de revisiter l'objectif initial du TCS.

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Johnson-Shoyama Graduate School of Public Policy, un centre interdisciplinaire de recherche, d'enseignement et de formation dans le champ des politiques et de l'administration publiques, qui est située à l'Université de Regina et à l'Université de la Saskatchewan.

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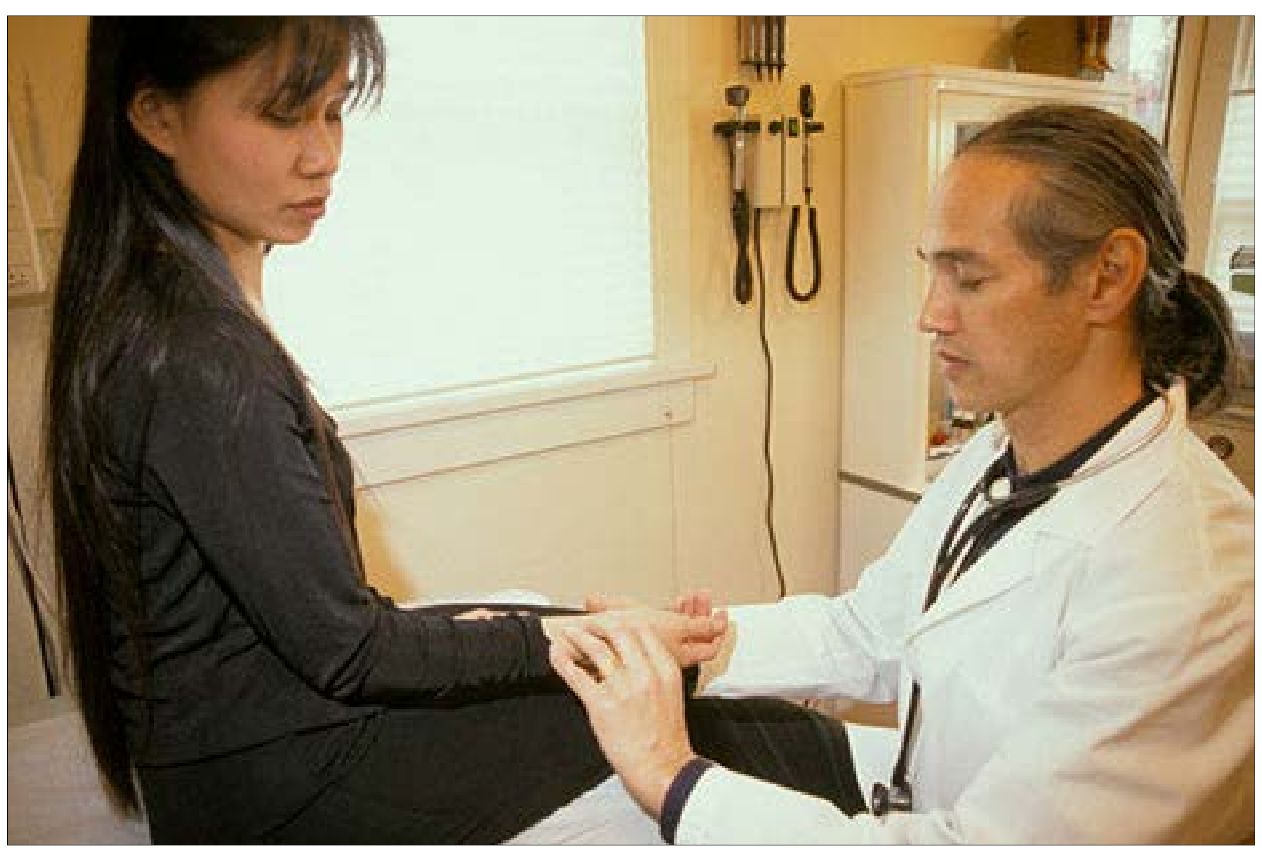
Chapter 2: Costs and Spending

Keeping doctors where we need them

Why incentives to attract more physicians to rural areas may be failing

MARIA MATHEWS



How do we get more doctors to practice in rural communities? This has been a long standing challenge in Canada — getting physicians to work where we need them — especially in provinces with large rural populations. Policy-makers have created and implemented some promising solutions, but until recently, there has been little evidence on whether or not the solutions are working.

Unfortunately, new research indicates that some programs aimed at retaining doctors in rural areas across the country may not be as successful as we'd hoped.

Almost all provinces and territories in Canada offer "return-for-service" agreements to attract and retain physicians in rural and underserved communities. Known by many names (including conditional scholarships, return-in-service bursaries, loan forgiveness programs), these agreements provide medical students and post-graduate residents with financial support for a commitment to practice in an underserved community, usually for one year for each year they receive support. Physicians have the option to pay back their funding if they can't complete their service commitments.

Return-for-service programs are seen as a key tool in addressing physician shortages, so much so that both the Conservatives and the Liberals promised a return-for-service program during the last

federal election, and the current federal government is rolling out their own program later this year.

In a study published recently in *Healthcare Policy*, my colleagues and I found that most medical trainees who take return-for service agreements in the province of Newfoundland and Labrador complete their service commitments in full. Moreover, return-for-service physicians stayed in these underserved communities for the long term (up to 10 years after their required service). We also found that return-for-service physicians were less likely to leave these communities than their counterparts who did not hold similar agreements.

Sounds pretty good, right?

Except that we also discovered that most physicians who choose to take return-for-service agreements wanted to work in these underserved communities in the first place.

Rather than finding new physicians who were uninterested in working in rural Canada, in Newfoundland and Labrador, these agreements appear to be encouraging already interested physicians to stay the course.

Our study also uncovered another important finding: of the 20 percent of physicians who defaulted on some or all of their return-for-service contract obligations, more than half were international medical graduates (IMGs) — physicians who graduated from a medical school outside of Canada.

Why might this be the case? IMGs are obligated to take a return-for-service agreement in order to obtain a residency position in Canada, which is a necessary step for full licensure. In other words, their return-for-service commitments aren't really as "optional," as with Canadian graduates. Results from our study suggest that few of these physicians go on to complete their service commitment or pay back their funding.

Using international medical graduates to fill physician shortages in rural communities is nothing new. In fact, many IMGs start their careers in Canada working under special licenses that allow them to work only in underserved areas. However, requiring IMGs to take return-for-service agreements will likely do little to stop the revolving door of short-stay physicians in rural communities. It is a stop gap, not a solution.

In 2013, the federal government will introduce its own "return-for-service program" to encourage physicians and nurses to work in underserved communities. Physicians can qualify for the program's financial incentive ($8,000 student loan remission each year for up to five years) if they work in "eligible" communities, defined in the federal program generally as a rural community with a population of 50,000 or less that is not near a large urban centre.

Unlike provincially run programs, the federal government's program does not require physicians to coordinate their "return" community with provincial planners so eligible communities may not necessarily be considered underserved from the local perspective.

Without meaningful coordination, provincial and federal return-for-service programs may end up being counterproductive and do little to resolve the physician shortages they hope to address.

And without meaningful follow up studies, the new federal program, like similarly structured provincial and territorial programs, may look good on paper, but fail to retain doctors in underserviced areas over the long term.

Problems with physician shortages in rural regions in Canada have existed for a long time. Isn't it about time we had a better idea about what actually works?

Maria Mathews is an adviser with EvidenceNetwork.ca and a professor of Health Policy/Healthcare Delivery at Memorial University of Newfoundland.

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What's wrong with hospital rankings?

Why "Rate my Hospital" needs a second look

MICHEL GRIGNON

The CBC's *Fifth Estate* recently produced an investigation on the quality of hospitals in Canada — "Rate My Hospital" — which has been enormously popular and set off discussions across the country about the need to improve our hospital services. Clearly getting a better picture about how our hospitals perform is of interest to Canadians, and the wish to exceed status quo health service delivery resonates with patients, policy-makers and healthcare providers alike.

So what's the problem?

Rate My Hospital is based on various pieces of evidence that were collected from patients, hospital workers and hospitals themselves (where they cooperated), along with data from the Canadian Institute for Health Information (CIHI). The general goal of the initiative is to make all of the information relevant to patients at the individual hospital level: anyone can go on the program's web page, pick a hospital, and learn about how well it performs.

Each hospital receives a letter-grade built on five standard indicators of hospital performance: mortality after surgery; readmission after surgery and medical treatment; and adverse events after surgery and medical treatment. CBC used indicators taken from CIHI annual hospital data, "standardized

them" within four peer-groups (teaching hospitals, large, medium and small community) and then assigned each hospital a grade.

So, instead of saying that St. Joseph's Healthcare (Hamilton) has a 5.34/1,000 mortality rate compared to 8 at the national level, Rate My Hospital determines that it is one standard deviation below the average in its peer-group, thus, it receives a letter grade A.

The goal of making data accessible and in a formula most of us can understand is laudable. Unfortunately, it is also misleading.

For starters, the formula assumes that each indicator contributes equally to the overall ranking. However, how can we decide that readmission matters as much as mortality?

But the main concern is that the ranking system is relative, not absolute. In any system, excellent or terrible, some hospitals will be one standard deviation away from the mean, by the very definition of the standard deviation. A standard deviation is the average distance to the mean. It necessarily takes some units to be distant by more than the average to get that average distance.

Does this mean that the information in Rate My Hospital is valueless?

Certainly not, but it should be of more interest to hospital CEOs than to patients or relatives. Patients do not really need an overall score for each hospital, because individual patients are admitted for a specific diagnostic: as a result, they should be much more interested to know how a given hospital performs on a specific treatment.

And what are the untold consequences of publishing evidence on adverse events at the hospital level and having patients use that evidence to decide where to be admitted?

It really depends on the origin of adverse events: if they result from overwhelmed providers in facilities used beyond capacity, publication of adverse events may have a welcomed balancing effect. That is, patients may move to facilities with lower occupancy rates and lower adverse events rates — a good thing.

But, if they result from caseload characteristics, such as more frail patients at one hospital than another, and if better informed, potentially less frail, patients are the most likely to use that information to select their hospital, some hospitals will end up with ever more complex and frail patients, whereas others will end up cherry picking the easy ones. In other words, it could lead to imbalance, and ever-greater disparity in outcomes between facilities.

Other data used by Rate My Hospital are similarly problematic, such as the survey in which hospital nurses were asked whether they would recommend their hospital to relatives. The results made headlines because, worryingly, 25 percent of nurses would not recommend their own institutions. However, this was not really a representative survey and it is quite likely that dissatisfied nurses were more willing to answer the survey (in the negative).

There is no doubt that having more information available on hospitals is good thing — and patients should make healthcare decisions based on good evidence. But patients do not need rankings based on assumptions and standardization that paint only a general portrait. Patients need more refined measurements of how a given hospital performs on a menu of relevant items specific to them.

We can't rely on the media to provide this. Perhaps it's time governments — and hospitals themselves — stepped forward and worked together with the media to make this happen.

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Don’t confuse money with quality at our hospitals

Jason M. Sutherland and Nadya Repin

Many people are willing to pay more for higher quality products. For example, you will be confident that a high- quality, brand-name TV will work when you get it home. If it doesn’t, the TV will be replaced free of charge.

The same is not true of hospital care in Canada, where there is no relationship between quality and spending.

Obviously surgery and TVs are radically different: you don’t need to replace your TV in quite the same way that you need to replace your kidneys. But while there is a financial incentive for companies to deliver a high-quality experience with manufactured goods, for hospitals, they are paid the same amount to treat patients regardless of the quality of care they provide.

Hospital quality isn’t a trivial worry. Many people know friends or relatives who have been made sicker by visiting a hospital, either through a hospital acquired infection or by receiving the wrong type or dose of medication. Although the rate of adverse events and medical mistakes has been going down since 2000, patients and health practitioners alike remain sceptical about the safety of our hospitals: over half of Canadians feel they will experience a serious medical error while in hospital and 74 percent of nurses feel likewise.

By and large, hospitals in Canada are paid one lump sum of money for the year to provide care to their patients. The payment is the same if a patient dies, goes home healthy, or if they experience complications and end up right back in the hospital or their doctor's office. Investments in infection control, changing hospital layout or purchasing new equipment to reduce opportunities for accidents are all viewed as additional burdens to fixed budgets — not opportunities to improve quality.

Recently, B.C. and Ontario have made reforms to the way they pay hospitals. The new policies pay hospitals, in part, based on the amount and type of work they do. However, neither the current or new ways to pay hospitals provide incentives for them to improve quality of care.

While additional spending does not always buy better health, some countries are now penalizing hospitals for providing low quality care. For instance, re-hospitalizations attributable to preventable errors are not reimbursed in the U.K., or by Medicare (the largest insurer of seniors in the U.S.). In Germany, re-hospitalizations within 30 days for the same condition are not reimbursed.

Ideally, we would like to reward hospitals for discharging healthy patients. But should Canada follow international trends and align hospital funding with quality?

Reports on hospital quality and spending are publicly reported and could provide the basis to enable these policies; the Canadian Institute for Health Information (CIHI) reports these statistics routinely.

In B.C., the 30 day re-hospitalization rate for the Surrey Memorial hospital is 7.7 per 100 hospitalizations. The same rate at the Chilliwack General Hospital is 9.9 per 100 hospitalizations, or an additional two re-hospitalizations per 100 patients.

In the U.K. or German healthcare systems, Chilliwack General Hospital would see some reduction in its funding owing to some portion of the re-hospitalization costs of patients.

The figures show how hard this adjustment would be. Surrey Memorial spends $4,630 per hospitalization and Chilliwack spends $5,220 (each is adjusted for patient's age and disease burden), but how much of this amount could be withheld for poorer quality care? There is no evidence to guide how much penalty would be a deterrent for hospitals.

Too little, and the penalty is considered too small to affect hospital behaviour. Too much, and hospital quality could be jeopardized further. Until the evidence becomes clearer regarding the link between financial penalties and quality, maybe these statistics can only offer a window on opportunities to improve quality of care.

Healthcare is fundamentally different from purchasing consumer goods; you can return your faulty TV, but you can't return your faulty surgery. The reforms in B.C. and Ontario demonstrate that there is an appetite for changing how hospitals are funded, but if we are to reward high-quality hospital care, a key question is how to do so.

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Il faut éviter de confondre argent avec qualité des soins dans nos hôpitaux

Le Québec devrait considérer d'autres protocoles de financement pour ses hôpitaux

JASON M. SUTHERLAND ET NADYA REPIN

Nombre de personnes sont prêtes à payer davantage pour obtenir des produits de qualité supérieure. Par exemple, si vous achetez un téléviseur, vous aurez la certitude qu'elle fonctionnera bien lorsqu'elle sera dans votre salon. Si ce n'est pas le cas, l'appareil sera remplacé sans frais.

Mais cette règle ne s'applique pas aux hôpitaux canadiens, où argent ne rime pas avec qualité des soins.

Évidemment, la chirurgie et les téléviseurs sont deux choses tout à fait différentes. Vous n'êtes pas obligé de remplacer votre télé, alors qu'un remplacement de reins, c'est autre chose. Mais bien que les entreprises aient intérêt, sur le plan financier, à offrir de bons produits aux consommateurs, les hôpitaux eux, reçoivent les mêmes sommes pour traiter les patients, peu importe la qualité des soins dispensés.

La qualité des soins n'est pas une question banale. Nombreux sont ceux qui ont un parent ou un ami dont l'état s'est aggravé pendant une hospitalisation, après avoir contracté une infection nosoco-

miale ou reçu le mauvais type ou la mauvaise dose de médicament. Bien que les taux d'incidents et d'erreurs médicales diminuent depuis 2000, les patients et les professionnels de la santé demeurent sceptiques quant à la sécurité des hôpitaux. Plus de la moitié des Canadiennes et des Canadiens sont convaincus qu'ils seront victimes d'une grave erreur médicale lors d'un séjour à l'hôpital, et 75 pour cent des infirmières sont aussi de cet avis.

En général, les hôpitaux au Québec, tout comme c'est le cas dans les autres provinces canadiennes, reçoivent annuellement un montant forfaitaire pour fournir des soins à leurs patients. Cette somme demeure la même peu importe si le patient décède, retourne à la maison en bonne santé ou s'il vit des complications et se retrouve une fois de plus à l'hôpital ou chez son médecin. Les investissements pour contrôler les infections, réaménager les espaces hospitaliers ou acheter de nouveaux équipements pour réduire les risques d'accidents sont vus comme un mal nécessaire dans un budget fixe, et non des occasions pour améliorer les soins.

Récemment, la Colombie-Britannique et l'Ontario ont modifié leur façon de financer les hôpitaux, et le Québec observe leurs démarches.

Selon les nouvelles politiques en Ontario et en C.-B., les hôpitaux sont payés selon la quantité et le type de soins dispensés. Toutefois, les actuels et nouveaux protocoles de financement des hôpitaux ne comportent aucun incitatif pour améliorer les soins.

Bien que l'injection de fonds supplémentaires n'améliore pas les résultats sur le plan de la santé, certains pays pénalisent maintenant les hôpitaux qui fournissent des soins de piètre qualité. Par exemple, les réhospitalisations attribuables à des erreurs évitables ne sont pas remboursées au Royaume-Uni. Il en va de même pour Medicare (le plus important assureur de personnes âgées aux États-Unis). En Allemagne, les frais de réhospitalisation pour un même problème de santé dans les 30 jours suivant un congé ne sont pas remboursés.

Idéalement, nous voulons récompenser les hôpitaux qui ne donnent un congé que si le patient est guéri. Par ailleurs, le Québec et le Canada doivent-ils suivre les tendances internationales et arrimer financement des hôpitaux avec qualité des soins? La qualité et les dépenses des hôpitaux font l'objet de rapports publics, lesquels pourraient alimenter l'élaboration de ces politiques. L'Institut canadien d'information sur la santé (ICIS) publie régulièrement de telles statistiques.

Au Québec, le taux de réhospitalisation de 30 jours au CSSS de Gatineau est de 7,03 pour 100 hospitalisations. Le taux au CSSS de Chicoutimi est de 8,3, ou une réhospitalisation de plus pour 100 patients.

Au R.-U. ou en Allemagne, la réhospitalisation de patients et les coûts occasionnés entraîneraient pour le CSSS de Chicoutimi la perte d'une part de son financement.

Les chiffres démontrent que de tels ajustements comportent certaines difficultés. Le CSSS de Chicoutimi consacre 4 089 $ pour chaque hospitalisation, alors que le CSSS de Gatineau en consacre 3 972 $ (chaque chiffre est ajusté selon l'âge du patient et la charge que représente la maladie). Or, quel montant faudrait-il soustraire des 4 089 $ pour cause de soins déficients? Il n'existe aucune donnée probante qui indiquerait le montant à soustraire pour dissuader les hôpitaux de dispenser des soins médiocres.

Si le montant est modeste, la pénalité sera trop légère et l'établissement ne modifiera pas ses façons de faire. S'il est trop élevé, la qualité des soins risquent de dépérir davantage. Tant que nous ne disposerons pas de données probantes sur le lien entre les sanctions pécuniaires et la qualité des soins,

ces statistiques n'offriront qu'un aperçu de ce qui peut être fait pour améliorer les soins.

Les soins de santé relèvent d'un tout autre domaine que l'achat de biens de consommation. Vous pouvez rapporter votre télé mais vous ne pouvez pas rapporter une chirurgie mal faite. Les réformes exécutées en C.-B. et en Ontario démontrent la présence d'une volonté de changer la manière de financer les hôpitaux. Cependant, si nous voulons récompenser les établissements qui prodiguent de bons soins, il faut répondre à la question clé : comment devons-nous procéder?

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How the federal government plans to end homelessness

Housing First approach highly effective

Vicky Stergiopoulous and Sam Tsemberis

Something largely overlooked by wide media coverage of the federal government's Economic Action Plan 2013 was that it marked a significant change in the way we will tackle homelessness in this country. The plan includes an investment on ending homelessness by providing five years of renewed funding for the Homelessness Partnering Strategy (HPS), and placing a strong emphasis on the Housing First approach.

The sizeable investment, $119 million per year for five years, is commendable in two ways: it increases the funding cycle of HPS from three to five years, and, notably, it signals a significant change of course by the ministry — addressing homelessness will now include more direction by the federal government, combined with effective local community planning.

Approximately 60 communities across the country are supported by HPS funds, and 80 percent of the funding goes to Canada's 10 biggest cities. Without HPS funding, the number of people who are homeless would increase dramatically.

But the federal government has done more than allocate scarce budget resources to a growing concern, they've also advocated a Housing First approach to homelessness. What does this mean ex-

actly? It means that the policy lens dramatically shifts across the country from supports for "helping the homeless" to "ending homelessness."

Housing First programs have been shown across the U.S to effectively end homelessness by providing immediate access to housing and support services and then providing treatment and support services. Previously, individuals had to meet milestones (such as sobriety and mental health counselling) just to be eligible for housing.

In Canada, we conducted the largest randomized controlled trial of its kind in the world on homelessness by comparing Housing First to services as usual (the At Home/Chez Soi study) involving 2,255 participants who were homeless across five Canadian cities (Moncton, Montreal, Toronto, Winnipeg and Vancouver). The one-year results, recently reported by the Mental Health Commission of Canada, indicate that HF is significantly more effective than services as usual in providing stable housing for people who had been homeless for years and who have complex clinical needs.

Also compelling was the finding that for every $2 the government invested in the HF program, $1 was saved. Savings were even greater for those who used services the most, with $3 saved for every $2 spent.

It's no wonder the federal government supports Housing First: it is highly effective and can save money.

So Canada is on the right track. We have both funds and evidence-based policy for moving forward on homelessness. However, we still face two major hurdles in order to successfully meet a Housing First model.

First, the majority of programs currently funded across the country can be described as "providing services for people who are homeless." Shelters, drop-in centres, and especially transitional or short term housing programs must be helped to shift resources to programs that "end homelessness" instead. We will need to invest in providing training and consultation services to communities so they will obtain the guidance and support, time lines, and performance indicators necessary to move the system towards this new, much-needed direction.

The second hurdle concerns implementing Housing First programs so that they are consistent with the basic principles of the model that achieved the outstanding outcomes in the At Home/Chez Soi study. Housing First moves people rapidly from shelters or the streets into stable housing and provides evidence-based clinical and social supports to address social, mental health, health, addiction, educational, employment and other issues. By providing services using a team approach and coordinating housing, clinical, and social supports, this model reduces problems associated with fragmentation of services and improves inter-sectoral collaboration that usually plagues individuals and families seeking treatment.

In other words, Housing First, if implemented properly, will transform public services across the country as we know them, and to do this effectively, teams will need adequate support and guidance.

Continued investment in a homeless strategy and advocating for the widespread implementation of the Housing First approach is the right thing to do — a humane and effective intervention. It is also the smart thing to do — basing federal policy on rigorous research findings is a model that is laudable in any ministry.

The need now is for a sound implementation plan so we can move our community resources quickly

from serving the homeless to ending homelessness in our communities.

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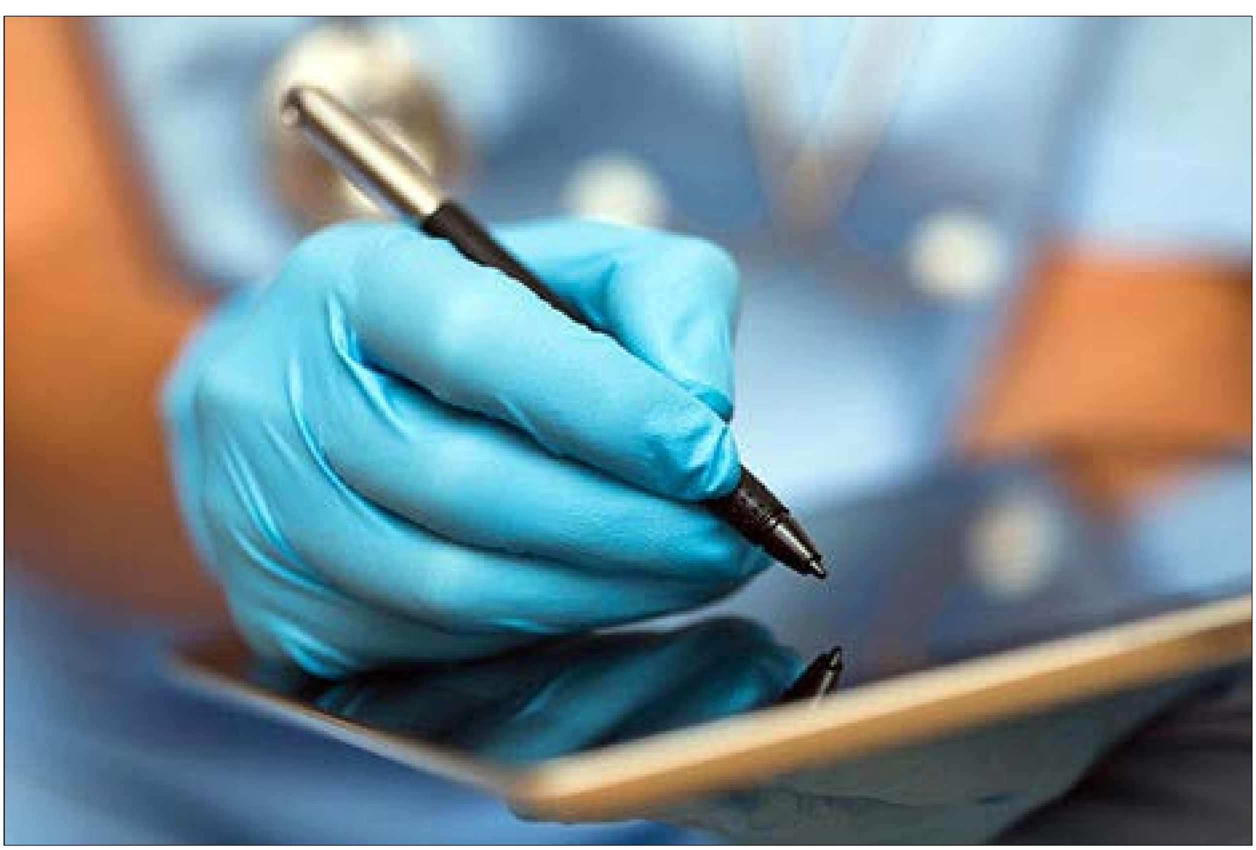
Moving Ontario hospitals into the 21st Century

Funding approaches that integrate care can improve access, costs and quality

Jason M. Sutherland and Erik Hellsten



When it comes to the way we fund our hospitals, Ontario is only now moving beyond the 8-track era. The government is modifying its outdated payment systems to try and change the same old tune that has played for decades: long wait lists, bed blockers and cancelled surgeries.

Ontario pays for most of its hospital care using the same global budget "lump sum" approach it has used since the late 1960s. Meanwhile, the rest of the industrialized world has spent the last 30 years moving to funding models that pay hospitals based on the types and quantities of patients they treat.

At the same time as these kinds of long overdue hospital funding reforms are being contemplated in Toronto, forward-thinking countries are already shifting to the next generation in healthcare funding: paying for care that stretches beyond the walls of the hospital.

Ontario should take note. We may be showing up late to a party where the guests have already moved on.

There are good reasons for provinces to break away from their traditional reliance on global budgets. Global budgets are essentially annual entitlements that are largely based on legacy and don't keep

pace with changing patient demographics or community-based models of care. Worst of all, they can drive hospitals to ration care and prolong wait times in order to keep costs down, rather than improving their efficiency.

These sorts of issues have pushed countries like Sweden and England to move from global budgets to a per-patient funding approach that pays hospitals through fixed prices for each type of patient based on the complexity of treatment required. Per-patient funding motivates hospitals to treat each case more efficiently and to increase the number of cases they treat in order to increase their revenue.

Under this approach, hospitals begin to admit more patients and discharge them more quickly. More patients are treated for the same number of beds.

But as wait lists shrink, many countries also see rises in their total hospital spending driven by the increased numbers of admissions. For some countries, per-patient funding was implemented during fiscal booms to tie new cash influxes to tangible results. Despite making similar cash infusions over the same period, patients in many parts of Ontario still struggle with wait lists.

The government of Ontario has finally had enough and is now slowly introducing per-patient funding in a cash-strapped climate. Only a few types of patients are funded with the new "Quality-Based Procedures" policy, with little cash to spare for buying additional volumes of care.

Elsewhere, countries that have used per-patient funding for years, like the U.S. and England, are now wondering if it's time to move on. Traditional hospital-focused patient funding does a good job of buying more surgeries, but it doesn't do much to address the challenge of coordinating care across healthcare providers.

Our hospitals, doctors and community providers are badly fragmented. We pay each provider using a different payment model, with no financial incentives for providers to work together. New models of funding healthcare that use shared incentives to motivate communication and safe transitions between providers are needed for today's complex patients.

There are now some promising experiments with new integrated payment models that attempt to bridge these gaps in care. In the U.S., the Obamacare reforms have launched a wave of projects to manage populations of patients. These next generation payment models reward hospitals for their ability to prevent the admission of people with chronic illnesses like diabetes, where a hospital admission is a sure sign of failure.

Ontario faces a tough challenge ahead: do they expand traditional hospital-focused per-patient funding to try and reduce stubborn wait lists?

Arriving late to this party has a silver lining. Instead of pouring money, time and effort into upgrading our 8-track funding models to cassettes, we can learn from what others have done and skip a generation in payment reform.

By introducing per-patient funding approaches that also integrate payments across hospitals, physicians and community care providers, Ontario can begin to tackle the triple challenge of access, cost and quality rather than passing the buck from one healthcare sector to the other.

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can be found at www.cdhowe.org.

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Canada sees increase in number of doctors, but at a cost

Physician workloads decreasing while their incomes are rising

Livio Di Matteo

Physicians are the second largest component of provincial government health spending in Canada, averaging about 20 percent of overall healthcare budgets — and constituting one of the fastest growing public health sector costs of recent years. This is despite the fact that Canada has relatively few physicians compared to many other developed countries.

According to 2013 OECD health statistics, at 2.4 practicing doctors per 1,000 people, Canada ranks 28th out of 34 OECD countries. These countries range from a high of Greece — with 6.1 practicing doctors per 1,000 people to Chile's low of 1.6. Canada is just behind the United States at 2.5 and ahead of Japan, Mexico and Poland — all tied at 2.2.

Recent Canadian growth in physician ranks has some pundits alarmed. However, in a new study for *Health Policy*, I demonstrate that it is not growing physician numbers that we need to worry so much about. The greater strain on our health budgets will come not from more doctors, but from more doctors earning more while working less.

Estimated determinants of provincial government health spending show physician numbers alone are indeed a positive driver of healthcare spending after controlling for other factors. From 1975 to

2009, the increases in physician numbers accounted for a range of about three to 13 percent of the increase in average real per capita total provincial government health expenditures, ranging from a low of two to eight percent for Manitoba to a high of five to 18 percent for Quebec.

These results support the conventional wisdom that expansion in the number of billing physicians is itself a driver of health system spending. Yet, physician numbers contribute less to spending increases than do increasing fees and service volumes. Indeed, a Canadian Institute for Health Information (CIHI) study on health cost drivers found new technology, utilization and price inflation to be at the top of the list, along with population growth and aging.

We also need to recognize that many of our doctors are working fewer hours than generations past. One study found that 27.7 percent of Canadian family doctors (FP/GPs) reduced their work hours between 2005 and 2007, and that 33.9 percent of them planned further reductions in their weekly work hours between 2007 and 2009. Only 8.1 percent planned to increase their weekly working hours. Another study found that younger and middle-aged family physicians carried smaller workloads than their same age peers a decade earlier. Older physicians — many who are approaching retirement — are carrying a heavier workload relative to younger physicians.

This, while according to CIHI, payments to physicians for their services continue to grow — rising six percent in 2010–11, after increases of 9.7 percent in 2008–09 and 7.9 percent in 2009–10. While total physician numbers are growing, for many physicians, their individual workloads appear to have declined but their compensation has not.

Doctors do work long hours and it is understandable they may desire a better work-life balance. However, in an era of tight public budgets, having more physicians doing less and costing more may be seen as a luxury. This sentiment was undoubtedly a driver behind Ontario's recent decision to tackle physician fees, especially given that physicians in Ontario account for about one-quarter of the government's health spending — the highest share in the country.

The recent increases in physician numbers from ramped up medical school enrollment may not be the biggest cause for concern when it comes to future healthcare spending. Rather, the drivers of public healthcare spending are a complex interaction between physician numbers, physician decision-making, physician work-load, diagnostic and drug technologies, population growth, aging, the cost and deployment of human resources, provincial health system institutions and the role of demand side economic variables such as incomes and patient preferences.

So what can be done?

Future cost control in health spending will either need to restrain growth in service volumes and utilization — an unpopular move with the public — or it will need to tackle fees much more directly — an unpopular move with healthcare providers.

One thing is certain: the recent trend toward doing less for more is not a sustainable option.

Livio Di Matteo is an expert adviser with EvidenceNetwork.ca and a professor of economics at Lakehead University. His recent study, "Physician Numbers As a Driver of Provincial Government Health Spending in Canadian Health Policy," appeared in Health Policy.

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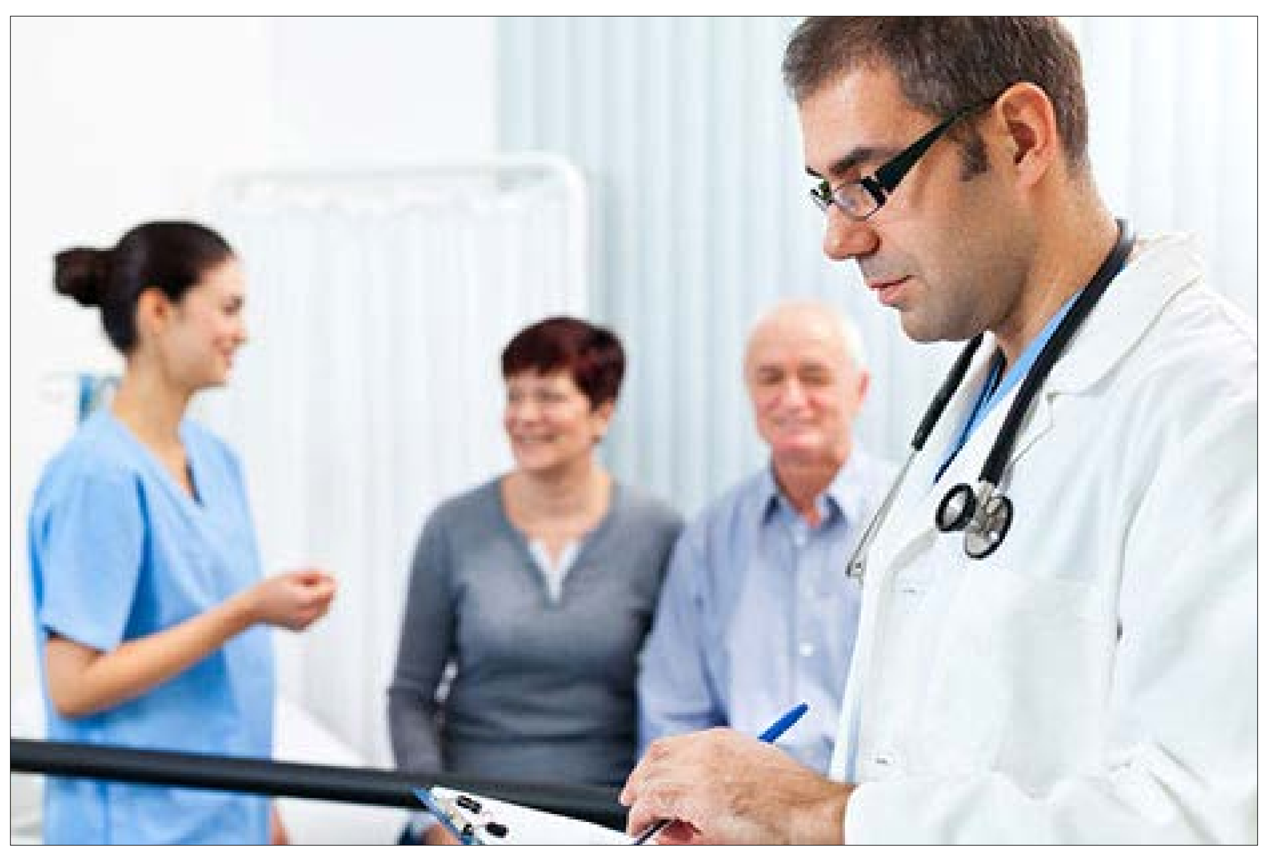
A version of this commentary appeared in *the Globe and Mail*, *the Vancouver Sun* and the New Brunswick *Telegraph-Journal*.

What doctor shortage?

Canada soon to be awash in new doctors

MORRIS L. BARER AND ROBERT G. EVANS



Earlier this year the Paris-based Organization for Economic Cooperation and Development released the results of a survey of average waiting times for medical care in 25 countries. This was not a shining moment for Canada.

Waits for most medical services are far longer here than in most of the comparator countries. This is simply the latest evidence seemingly supporting the rhetoric of a "doctor shortage" that has been a recurring theme in the Canadian public discourse for the past 20 years. But let's take a closer look at the evidence.

Over the past 15 years, first-year medical school enrolments in Canada have almost doubled, from 1575 in 1997–98 to about 3000 in 2012–13. The number of foreign medical graduates entering practice in Canada annually has also more than doubled since the year 2000. Over that same period, the number of Canadians who obtained their medical degrees internationally and entered practice in Canada annually has increased 250 percent.

The Canadian Institute for Health Information (CIHI) reports released this month indicate that between 2008 and 2012 the number of physicians rose three times faster than the growth of the over-

all population, and for the sixth year in a row, the number of physicians per population has reached a new peak and is continuing to rise.

While this need not necessarily translate into equivalent amounts of additional care provision, it does highlight some troubling trends. We are only just beginning to see the effects of the expansion in domestic training capacity. In other words, we are in the early stages of a dramatic expansion in physician supply that will continue for decades.

Canada will soon have too many doctors. Contrary to the continuing doctor shortage rhetoric from ill-informed or interested parties, a "physician glut" appears already to be in the pipeline.

But, we are told, Canada needs more doctors because the population is aging. True enough, but every study ever done has found that demographic change adds only about 0.5 percent annually to per capita use of services.

Well, what about the women? The physician workforce is becoming increasingly feminized and female physicians put in fewer hours per year over a lifetime of practice; so goes the argument. Moreover, younger male physicians are also working fewer hours than their predecessors. So, many more doctors will be needed.

But again, the awkward facts intrude. Average medical expenditures per physician in Canada (adjusted for fee changes) have been rising, not falling, even as the overall supply expands and becomes increasingly female. If average hours of work are falling, how is it that adjusted payments per physician are rising? Either physicians are delivering more services per hour, or their fees are actually rising much faster than the official fee schedules show (or both).

And if they are finding ways to deliver more care, in spite of putting in fewer hours, how is it that we need more doctors?

None of this denies the fact that some patients continue to have difficulty finding family doctors, and face excessive waiting times, particularly for certain specialists and some diagnostic tests and surgeries. But evidence is beginning to emerge of Canadian-trained doctors who cannot find work. We suspect this is the beginning of a new and unfortunate trend.

Nevertheless, some pundits and politicians advocate pumping more doctors into the system, by making it easier for Canadians studying medicine abroad (CSAs) or foreign-trained medical graduates (FMGs) to enter practice in Canada.

This would be an obvious response to a doctor shortage — if there was one. An estimated 3,570 Canadians are currently studying medicine at schools in the United Kingdom, Australia, Poland, the Caribbean and elsewhere. Assuming a four-year training program, these CSAs represent a potential increase to domestic supply of nearly 900 new physicians per year, well above the numbers of CSAs entering presently.

Alas, a barrier stands in their way: to enter practice they must not only pass Canadian qualifying examinations and complete residency (specialty) training here; but there are far fewer residency positions available for CSAs than there are CSAs looking for them. Should Canada create and fund more residency slots for them? At another time and place the case might be compelling. But not here, and certainly not now.

What is needed, instead, is a comprehensive and coordinated set of national policies that recognize the reality of the new domestic training situation, and use the opportunity to better manage the

overall system, and get physicians with the right training, expertise and resources to where they are needed.

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Robert Evans is an emeritus professor of economics, UBC.

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More health specialists not the answer to health system woes

It's time to rethink medical education in Canada

BEN CHAN

It was only a decade ago that headlines in Canada were filled with pessimism about the nation's critical doctor shortage. Wait times for specialists were increasing, doctors were leaving for the U.S. and patients couldn't find a family doctor. Yet a recent study from the Royal College of Physicians and Surgeons of Canada notes that today, one in six new health specialists cannot find work.

Surely, this must be disheartening for recent graduates, who, after 10 to 14 years of post-secondary education, are underemployed and saddled with huge debt loads.

Can we at least take solace in the fact that our health system has improved as a result of this big investment in medical education? Unfortunately, the bright spots are hard to find.

Let's look at the regional distribution of doctors in Canada. In rural and remote areas across the country, access to specialists remains a huge barrier. A quick check of the Ontario government's website, for example, shows that wait times for orthopaedic surgery is 261 days in Thunder Bay, compared to about 110 days in Toronto. We have more doctors, but not necessarily where they are

needed most.

What about quality? In my past research on the perceived physician shortage in 2002, I found that the single biggest factor behind the drop in doctor supply was the decision by certifying bodies to increase the length of training for most specialties. The presumed justification for this was to improve physician skill, which in turn would improve quality of healthcare.

The problem, however, is that most quality defects are not due to lack of provider skill, but to poorly organized patient flow, poor communication and poor teamwork. One in 50 patients in hospital is harmed unnecessarily due to the care they receive. Best practices — such as ensuring the right drug or test is done at precisely the right time — don't happen about half of the time.

These quality problems exist not because doctors are not well trained, but because healthcare has become so complex. It is easy for the human mind to forget to do the right thing, be distracted, or lose track of all the pieces of information that need to be communicated. Tools, such as electronic medical records that provide reminders and prompts, communication protocols, checklists and standard processes like what airline pilots use when they take off and land, are what the health system needs most.

Increased length of training may have also hindered the flexibility of our workforce, just when flexibility is at a premium. Medicine will soon face a wave of disruptive technologies driven by genetics, consumer-accessible devices and micro-implants. Already, heart surgeons face tough job prospects because better cardiac stents have reduced the need for cardiac bypass. Soon, gastroenterologists will lose their bread-and-butter colonoscopy, replaced by pill-sized cameras that one swallows. Right now, I can buy attachments to my iPhone that let me do an electrocardiogram or ultrasound. While such devices will never eliminate the need for specialists, they may dramatically change which specialists are needed and how specialists are used.

Clearly, our medical education system needs to tackle some tough questions if it is to do a better job of serving the public. Will we continue to do most specialty training in urban centres, or will there be the political will to dramatically shift training to smaller, underserviced communities? (Most studies show that doctors tend to practice close to where they were trained.)

Could we shorten residency training, by focusing more on demonstrated skills rather than time spent in the program? Do we still need rigid boundaries between specialties, or could more procedures be shared by different specialties, family doctors or other professionals, to increase flexibility to meet local needs? Will formal residency-style training continue to be something done mostly in one's early years, or rather something done in short stints several times throughout one's career?

Lastly, and most importantly, are our medical educators prepared to submit to a national strategy for managing health human resources? It's clear we need one.

These solutions are tough to implement, because some training programs will need to "give up" something they already have — students, funding, autonomy or "clinical turf" — while other programs gain as a result. Governments and the medical establishment will need to work together and set aside vested interests to maximize the public good. It's not an impossible task, but an essential one, necessary for the health of Canadians.

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provincial level.

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Saving our health system means reining in costs for doctors, tests and drugs

Canadian actuaries paint a bleak future for Canadian healthcare

MICHAEL WOLFSON

The Canadian Institute of Actuaries (CIA) recently painted a frightening portrait of Canadian healthcare, with projected costs growing to the point where little money will be left in provincial budgets for anything else — roads, schools, jails. While the report is solid, it is gentle in identifying the real issues we need to tackle.

The actuaries start with Canada's growing and aging population, which they identify as one important factor. They then look back at how fast healthcare costs have been growing over and above population growth and aging. But when they project using these historical rates, the result is too implausible, with healthcare spending going over 100 percent of provincial budgets. So the actuaries just chose their own lower growth rates, without any basis in fact — slow enough that their main projections are not wildly implausible, but still scary.

On our aging population, it is true that the elderly consume more healthcare services than the non-elderly. For example, the Canadian Institutes of Health Information (CIHI) estimate provincial spending for those age 40 to 45 at $2,100 per capita, while it was $26,000 for those age 90+ in 2010. But UBC's Centre for Health Services and Policy Research continues to stress this is a "zombie" explanation for rising healthcare costs — it has been slayed repeatedly by the evidence, but keeps rising from the dead. Indeed, a 2013 study from Alberta Health pegged aging at a manageable 0.8 percent of their healthcare cost increases over the past decade, while wage and other inflation and "unknown" factors accounted for a 6.6 percent increase.

So what's actually driving our healthcare costs? A large part of the increase comes from three main areas: new technologies such as diagnostic tests and drugs, and physicians.

There have been miraculous technological advances, but diffusion of many new technologies is largely uncontrolled. Many MRI and CT scans, for example, provide life-saving benefits. But others have no impact at all on the patient's course of treatment or health outcome, wasting both skilled professionals' time and healthcare dollars.

Same with drugs. One recent study randomized a group of seniors who were regularly taking an average of nine drugs — half continued, while the other half were advised by an independent physician to drop, on average, four of their drugs. The result: those on fewer drugs felt better and were healthier.

Another major cost driver completely unrelated to population aging is the incentives facing physicians, the gatekeepers to healthcare, and to healthcare costs. If a doctor does more surgery, he or she makes more money, becomes more proficient, and gains prestige. Proficiency is important — healthcare should be organized so that services are concentrated in high volume centres where specialized expertise can better be applied. Unfortunately, Canada's healthcare is not always so organized.

More importantly, more surgery is not necessarily better. In a 2009 study, we looked at 30-day survival after treatments for heart attacks (bypass surgery or angioplasty). For many health regions, there was no difference at all, while the proportions treated ranged from 20 percent to 60 percent. There are several possible explanations, one being this three-fold difference results from overly aggressive — and very costly — treatment that, in the end, was unnecessary.

How can such inappropriate use of healthcare persist, especially when the economic stakes are so high?

One major issue is lack of information — we simply do not have the data to assess whether a given hip replacement prosthesis has a good track record, when longer term side effects from pharmaceuticals are emerging (think Vioxx), or why some surgical teams have better results than others.

Why are these data lacking? It's not the computer science. We should look instead to physician resistance and an insidious but pervasive "privacy chill."

No one likes someone looking over their shoulder at their work. Most of us have no choice. But physicians are in uniquely powerful positions, and a critical mass have subtly but successfully resisted needed information being assembled and analyzed. They (perhaps correctly) fear that egregious examples of incompetence will be revealed. But as patients, we should welcome the significant improvements in quality of care — and as taxpayers, improved cost effectiveness — that would result.

Fears about personal privacy are also delaying needed health information. Some concerns are legitimate, but these are surmountable. Healthcare leaders have all kinds of opinion polls and focus group results showing that Canadians are more than willing to have their healthcare records analyzed statistically by bona fide researchers if it will improve healthcare quality.

Of course increasing healthcare costs are a problem. But let's not blame an aging population or generalized pressures for increased spending. We need to focus on real causes — not least, the missing information and analysis that will make some doctors and health ministers uncomfortable, but in the end, make us all better off.

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L’assainissement des coûts liés aux services des médecins, aux examens et aux médicaments peut sauver notre système de santé

Les actuaires canadiens brossent un tableau sombre des soins de santé au Canada

MICHAEL WOLFSON

L’Institut canadien des actuaires (ICA) ont récemment brossé un portrait qui fait dresser les cheveux en matière de soins de santé au Canada. Les coûts projetés augmentent de façon si soutenue que les provinces auront bien peu d’argent pour s’occuper d’autres besoins, comme les routes, les écoles, les prisons. Bien que le rapport soit étoffé, il cerne peu les vrais enjeux auxquels nous devons nous attaquer.

Les actuaires se penchent d’abord sur la population vieillissante, qui, selon eux, constitue un facteur important. Puis, ils examinent la vitesse à laquelle les coûts des soins de santé grimpent et dépassent la croissance et le vieillissement démographique. Toutefois, lorsqu’ils projettent en s’appuyant sur ces données historiques, les résultats sont invraisemblables et présagent un dépassement des budgets provinciaux en santé excédant les 100 pour cent. Les actuaires ont donc choisi de s’appuyer sur des taux de croissance inférieurs, sans s’appuyer sur des fondements. Ces taux sont suffisamment progressifs pour appuyer leurs principales projections, tout en suscitant certaines inquiétudes.

Concernant la question de la population vieillissante, il est vrai que les aînés utilisent davantage les services de santé que les plus jeunes. Par exemple, l’Institut canadien d’information sur la santé (ICIS) estimait à 2 100 $ par tête les sommes provinciales dépensées pour les personnes âgées de 40 à 45 ans en 2010, alors que ce chiffre grimpait à 26 000 $ chez les 90 ans et plus. Mais le Centre

for Health Services and Policy Research de l'Université de la Colombie-Britannique maintient que cette explication qui justifie la hausse des coûts des soins est un argument « zombi ». Les données probantes l'ont éliminée à maintes reprises mais elle ne cesse de ressusciter. En 2013, une étude d'Alberta Health constatait que la hausse des coûts des soins de santé recensée au cours de la dernière décennie relativement au vieillissement s'élevait à 0,8 pour cent, un taux jugé gérable. Toutefois, les salaires, l'inflation et d'autres facteurs « inconnus » comptaient pour 6,6 pour cent de l'augmentation des coûts.

Donc, qu'est-ce qui fait grimper nos coûts en matière de santé? Une part importante de ces hausses est liée à trois principaux points : les nouvelles technologies, comme celles appliquées pour les examens diagnostics; les médicaments; et les services des médecins.

Les avancées technologiques font des miracles, mais la dissémination de ces nombreuses nouvelles technologies se fait en grande partie de façon incontrôlée. Nombre d'examens IMR et tomodensitométriques sauvent des vies, alors que d'autres n'ont aucun effet sur le traitement ou les résultats de santé du patient et représente un gaspillage du temps des professionnels qui interviennent et de l'argent consacré à la santé.

Il en va de même pour les médicaments. Une récente étude randomisée s'est penchée sur un groupe d'aînés qui prenaient régulièrement une moyenne de neuf médicaments. La moitié de ceux-ci ont continué à prendre ces médicaments alors que l'autre moitié ont reçu d'un médecin indépendant la consigne de cesser de prendre, en moyenne, quatre de leurs médicaments. Le résultat : ceux qui prenaient moins de médicaments se sentaient et se portaient mieux.

La question des incitatifs auxquels font face les médecins, qui sont le premier maillon du système de santé et du coût des soins, constitue un autre élément important qui influe sur les budgets et qui n'est en rien lié au vieillissement de la population. Si un médecin fait plus d'opérations, il ou elle fait plus d'argent, est plus efficace et bonifie sa réputation. L'efficacité est un facteur important. Les soins de santé doivent être organisés de façon à ce que les services soient concentrés dans des centres à grand volume, où les compétences peuvent être davantage mises à contribution. Malheureusement, les soins de santé ne sont pas toujours structurés ainsi au Canada.

Plus encore, l'augmentation du nombre de chirurgies ne donne pas nécessairement de meilleurs résultats. Dans le cadre d'une étude réalisée en 2009, nous avons examiné le taux de survie après 30 jours, en lien avec des interventions pour une crise cardiaque (pontage ou angioplastie). Dans nombre de régions sanitaires, il n'y avait aucune différence, alors que le taux de personnes traitées variait de 20 à 60 pour cent. Ces chiffres s'expliquent de plusieurs façons. Notamment, ce triple écart découle de la prestation d'interventions extrêmement agressives — et très coûteuses — qui, en bout de ligne, ne sont pas nécessaires.

Comment un tel recours aux soins de santé inapproprié peut-il perdurer, surtout en la présence de si grands enjeux économiques?

L'une des causes est le manque d'information. Nous ne disposons tout simplement pas des données pour évaluer l'efficacité d'une prothèse de remplacement de la hanche, l'apparition d'effets secondaires liés à un médicament (p. ex. le Vioxx), ou les raisons qui expliquent pourquoi certaines équipes chirurgicales ont de meilleurs résultats que d'autres.

Pourquoi ces données sont-elles absentes? Il ne s'agit pas d'une lacune informatique. Nous devons plutôt examiner la résistance des médecins et une non-collaboration insidieuse mais répandue fondée

sur une argumentation défendant la vie privée.

Nul n'aime se sentir surveillé dans le cadre de son travail. La plupart d'entre nous devons subir une telle surveillance. Par ailleurs, les médecins sont dans une position de pouvoir unique et une masse critique d'entre eux ont résisté, de façon subtile mais efficace, à la cueillette et à l'analyse de données utiles. Ils craignent (peut-être avec raison) que des cas flagrants d'incompétence ne soient décelés. Mais en tant que patients, l'importante amélioration de la qualité des soins — et en tant que contribuables, de l'amélioration du rapport coût-efficacité — qui en découlerait serait pour nous bénéfique.

Certaines craintes portant sur la vie privée retardent la cueillette de données sanitaires importantes. Certaines préoccupations sont légitimes mais il existe des solutions. Les dirigeants des services de santé ont en main les résultats d'un large éventail de sondages d'opinion et de groupes de discussion qui démontrent que les Canadiennes et les Canadiens sont tout à fait disposés à ce que des chercheurs sérieux analysent leur dossier médical pour en faire des statistiques, si cette démarche améliore la qualité des soins.

Évidemment, l'augmentation des coûts des soins de santé est un problème. Mais ne pointons pas du doigt la population âgée ou n'attribuons pas cette hausse à la présence de pressions généralisées. Nous devons nous pencher sur les vraies causes et en particulier sur l'information et les analyses manquantes, ce qui causera un malaise chez certains médecins et ministres de la santé, mais en bout de ligne, nous nous en porterons tous mieux.

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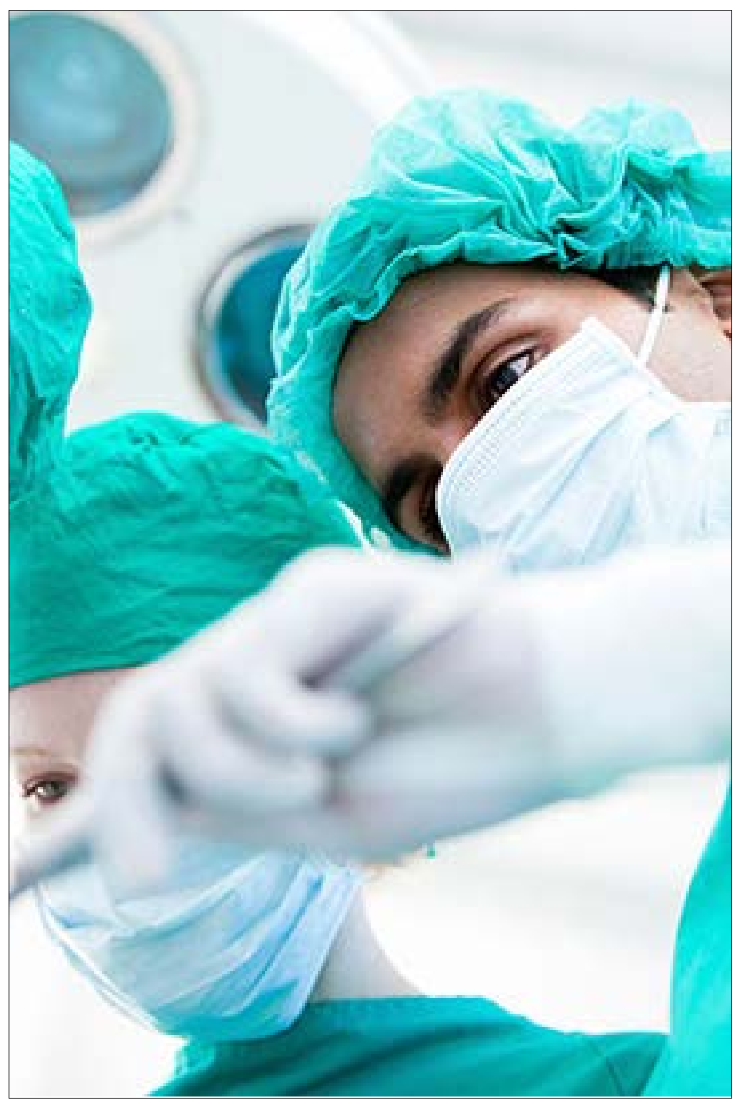
“Surplus” of medical specialists in Canada should come as no surprise

“Déjà vu all over again”

Morris Barer



The most surprising thing in the recent coverage of the Royal College of Physicians and Surgeons of Canada study, which notes that as many as one in six newly graduated medical specialists can’t find a job, is that anyone finds these results startling. They’re not if you’ve been paying attention.

The die was cast about 15 years ago, when the medical schools of the country convinced the provincial ministers of health at the time that Canada faced a dramatic shortage of physicians that could only be addressed by a massive ramp up in domestic medical school capacity. The result was an almost doubling of first year entry numbers, from about 1,575, to around 3,000 per year. Once you consider this fact, the arithmetic is breathtakingly easy, and the startle factor disappears.

Canada now has at least 85 percent more new physicians ready to enter practice each year, on average, than physicians retiring. And this is before considering Canadians who have gone to medical schools abroad and then returned to Canada hoping to practice here, or medical graduates from other countries. The numbers of both entering practice here have also increased dramatically over the past decade, and there is considerable pressure, particularly from Canadians who have gone abroad for training (currently about 3,500, with more joining every year) and organizations representing them, to increase numbers even further.

It is not that the “one in six” implies that Canada now has an overall surplus of specialists, any more than the widespread claims of shortage in the mid-1990s meant, then, that we had an overall

shortage of physicians. We had then, and we have now, an inability or unwillingness as a country to develop plans and policies designed to train and deploy physicians in a sensible manner.

The report's author is correct in noting that there is no quick fix here. The Royal College's plan to convene a meeting early next year to discuss a nationally coordinated approach to health system workforce planning may be a useful start. It is difficult to imagine the recommendations that might emerge from such a meeting being worse than the current uncoordinated mess.

At present, policy decisions, or often the lack thereof, are failing to meet the needs of new trainees — or of patients. For example, there are no national (and few provincial) mechanisms in place to channel new graduates into the specialties where they are likely to be most needed rather than into the specialties most needed by teaching hospitals or most favoured by students.

And despite the fact that we live in a hyperactive era of tweets and blogs in which the new generation seems to be constantly "connected," there is no structured electronic "meeting place" for job hunters and job seekers. New graduates are somehow failing to figure out where the jobs are (and there are, in fact, plenty of communities desperately seeking specialists).

In some cases, at least, the new specialists are simply the victims of the completely predictable fallout from that earlier medical school expansion. When those ministers of health agreed to fund an approximate doubling of medical school places, what did they think would happen when those students started graduating? Was there a plan in place to ensure that the complementary resources that are required for their practices would also be funded and in place?

In a word, "no." For example, operating room capacity — or at least "working capacity," meaning an available operating suite plus the funds, supplies and complementary staff to operate it — has not kept pace. To make matters worse, the capacity is not used efficiently, and some of those who control that capacity are not all that keen to share with their younger brethren.

The consequences of our future — many more new physicians looking for practice opportunities each year, than old physicians retiring — are as predictable as what we are seeing in the Royal College findings today.

Ministries of Health need to engage now in two separate but related conversations — one about policies designed to take advantage of all these new highly skilled and motivated physicians available to Canadians, and a second about how to avoid repeating old policy mistakes down the road. Memories, it seems, have a short half-life; mistakes don't.

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Linking hospital quality to payment

How we pay hospitals has a strong effect on how they behave

Jason M. Sutherland and Erik Hellsten

For several decades, the amount of funding that Ontario's hospitals receive each year has been based more or less on the funding they received the previous year, regardless of their patients or their performance. Over the next three years, the government plans to begin partially funding hospitals based on the number of patients they treat and the quality of care they provide. It's an ambitious plan that could fall flat or set a new global benchmark.

How we pay hospitals has a strong effect on how they behave. Changing the way hospitals are funded will have impacts on how patients access care and the type of care they receive. The traditional global budget lump sum funding approach still used by other provinces is widely seen to provide little motivation for hospitals to improve either their quality of care or their efficiency.

Ontario is introducing a new approach to the Canadian hospital funding scene, known as quality-based procedures (QBPs). The plan is to fund hospitals based on the volume of services provided at a given price. This will be applied to selected types of hospitalizations, such as knee replacements and stroke.

Funding hospital care based on a fixed price is commonplace in most of the developed world. But

what is innovative about the QBPs is the way the Ontario government plans to set the price. Expert panels of clinicians and researchers have been struck to determine "best practice" processes of care for patients — essentially, defining high-quality care for each disease or procedure. The government's plan is to then figure out what this best practice care costs and set prices for QBPs accordingly.

This is a significant change from the way hospitals tend to be funded, which is based on their average or historical costs. Linking prices to high-quality care has the potential to reduce unwarranted variations in spending and outcomes between hospitals.

Ontario has long led the way among the provinces in using data and information to drive its funding models, but the new payment concept is unprecedented not only in Ontario, but for world standards.

No country has yet managed to set a price on high-quality care.

The challenges are many and will pose serious hurdles for Ontario. For starters, the evidence regarding what makes for high-quality care is often ambiguous because each patient has a different level of acuity. For instance, how many days should a patient with respiratory disease stay in hospital? The degree of a patient's illness has a huge impact on hospital costs, yet good evidence to adjust for them is scarce.

There are few rigorous clinical trials pointing the way to a black and white definition of high-quality care. These gaps in the evidence will open up the government's QBP prices to being contested by hospitals, other healthcare providers, as well as drug and device producers.

Finally, the government's rollout scheme for the new policy is not without critics. The province is targeting QBP funding at certain types of patients and surgeries, adding stroke, congestive heart failure, chronic obstructive pulmonary disease, chemotherapy and colonoscopy to a short list that already pays hospitals with a fixed price for hip and knee replacements, chronic kidney disease treatments and cataracts. This risks creating a system where hospital revenue is attached to some patients but not to others. So some funded procedures become winners while others become losers.

There are huge benefits to be had if Ontario is able to realize its vision for new hospital funding. The approach has the potential to drive all hospitals to provide an equally high standard of care, regardless of location. If the prices paid to hospitals accurately reflect patient pathways defined by the expert panels and extend beyond the hospital walls, Ontario may finally be taking much-needed steps toward funding providers in a way that reduces fragmentation between sectors of the healthcare system.

Ontario's new hospital funding plan is hugely ambitious and other provinces are watching with interest. Paying hospitals based on the expected cost of high-quality care is an attractive idea, but is also an idea that has a ways to go before becoming reality.

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(March 2013)

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“Super users” of healthcare system the target of reforms

Building on local strengths key to cooling medical hot spots

Ryan Meili

An intriguing idea was recently put forward by the Government of Saskatchewan, that of addressing medical hot spots. It has been reported that just five people were responsible for visiting Saskatchewan emergency rooms over 500 times in the last year. One patient alone is said to have required over $1 million in health services.

A report earlier this summer showed that just 20 individuals in Saskatoon were costing a total of $2 million per year in health and social services. With a third of Saskatchewan's health expenditures going to serve just one percent of patients, it's no wonder the government is wanting to explore a different approach to health services.

Saskatchewan is not alone in this concern. Provinces and regions across the country are sitting up and taking notice too. Tightening health budgets across the country are leading people to take a different look at just where healthcare dollars are flowing.

The term, healthcare “super utilizers” or “super users,” was first coined by Dr. Jeff Brenner of Camden, New Jersey to describe individuals who, despite very high levels of health intervention and expense, are still suffering from very ill health. His work also outlines the existence of “medical hot

spots" — specific areas in a community that often incur the highest health bills.

The proposal from the Saskatchewan government to focus on medical hot spots and healthcare super-utilizers opens a fascinating dialogue about how we could re-imagine healthcare to be more effective, more equitable, and cost less, both in the province and across the country.

Surely there must be a way to help those most in need that is more effective and less expensive.

Some of the answers may come from innovative models developed elsewhere. Dr. Brenner and others have used regular interdisciplinary team huddles, community-engaged outreach workers, and other creative means of adjusting the rigid world of healthcare delivery to meet the complex and chaotic needs of patients. There is indeed much we can learn from these successes, but before we import too much from afar, we have some success stories of our own too, including from my neighbourhood on the West Side of Saskatoon.

In an interview on medical hot spots on an episode of CBC's *Black Coat White Art* that described this area of Saskatoon as exactly such a hot spot, Dr. Brenner referred to two local initiatives — Station 20 West and SWITCH — as "disruptive change," the sort of delivery system game-changers required to address persistent, complex problems.

SWITCH, the Student Wellness Initiative Toward Community Health is a student-run, interdisciplinary, clinic operating in inner city Saskatoon. For years, SWITCH, and its host, the West Side Community Clinic, have been taking a full service, low threshold approach to decrease barriers to healthcare and reach out to the hardest-to-serve patients. Station 20 West, a facility that includes a grocery store, housing cooperative, university outreach centre and more all in one location, moves beyond healthcare to focus on the upstream determinants of health — housing, income, nutrition, education and more — really acting like an outpatient hospital for the whole person.

Other Saskatchewan successes include the Prince Albert Police Service Community Mobilization meetings that bring various agencies around a single table to help address the needs of high-risk families, and the multiple levels of housing and social support offered by Saskatoon's Lighthouse.

The key to success in cooling medical hot spots will rest in scaling up existing local interventions like these — and others across Canada — magnifying existing strengths to help cope with the growing challenges of high-needs individuals.

Of course, addressing the needs of super users is only a first step. In many ways, these are the people that we have already failed. Meeting their needs is essential, but we should also be looking to help prevent those currently struggling from becoming the super users of the future by creating the conditions for better health.

Smart investments in the social determinants of health, including community economic development, can turn struggling neighbourhoods from medical hot spots into thriving, healthy communities.

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Chapter 3: Pharmaceutical Policy

Time to repair the drug patent process in Canada

Longer drug patents will not attract new research

STEVE MORGAN

In late October, the federal government signalled that, to reach a new trade agreement with Europe, it might extend pharmaceutical patents. The move could cost Canadians up to $2 billion per year. Supporters argue that it will attract research investment and generate jobs.

But longer drug patents will not attract new research to Canada.

Pharmaceutical firms locate research investments on the basis of the quality of local scientists and the cost of running clinical trials. If we want industry to invest in Canada, we need to invest in our capacity to conduct research. One way would be to double the budgets of the Canadian Institutes of Health Research — which would cost less than extending pharmaceutical patents.

But if Canada must change drug patents to win a trade deal, let's at least fix our broken intellectual property system while we are at it.

The patents that apply to other technologies fail the pharmaceutical sector. They fail for a number of reasons.

First, most patented medicines must be studied in clinical trials to establish that they are safe and effective enough to be sold to Canadians. This can take years after firms file their initial patents, which reduces the time they can charge monopoly prices (the "carrot" that patents create to give firms incentive to develop new drugs).

The proposal to give firms a guaranteed period of market exclusivity (i.e., a guaranteed length of monopoly sales) after regulatory approval would not only benefit firms, it would also allow regulators to demand better pre-market drug trials and to take more time to evaluate trial data.

The current rush to approve medicines while manufacturers' "patent clocks" are ticking means that

some medicines make it to market that later must be recalled because of harms they cause to patients — harms that could be detected with more thorough pre-market evaluation.

The second failing of the patent system for pharmaceuticals is that, although disclosure of scientific information is a key benefit of the patent system, the information of greatest value to society is not publicly disclosed when a patent is filed. This is because data about the safety and effectiveness of most medicines is gathered after patents are granted.

Few Canadians realize that pharmaceutical companies can and do keep regulatory data about safety and effectiveness secret. This secrecy should end. And it can be ended by making full public disclosure of regulatory data a condition of extended pharmaceutical patents.

Finally, the patent system fails in the pharmaceutical sector because nobody appears to know when generic competitors can enter the market. This is because pharmaceutical companies often file multiple, overlapping patents on the same drug and use these often-bogus patent claims to block regulatory approval of generics. This generates a lot of income for patent lawyers and consultants but provides no value to society as a whole.

If the International Trade Minister wants to extend drug patents, the Health Minister should use the opportunity to improve our regulatory system too: provide a clear and unambiguous period of market exclusivity after a drug has met high standards of pre-market regulatory approval; require that all data considered by that regulatory process be made available to the public; and allow all generic competition as soon as the period of market exclusivity has expired.

Such a system would be a windfall for truly innovative pharmaceutical companies, would dramatically improve regulatory transparency and would likely mitigate the aggregate cost-impact of conceding pharmaceutical patents as part of our trade negotiations.

But simply granting longer drug patents under the guise of attracting research investment is patent nonsense.

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Manufacturing anxiety about generic drug prices

Michael Law and Jillian Kratzer

Generic drug companies often present themselves as a modern-day Robin Hood: taking from brand name drug companies and passing the spoils on to Canadians. Public debate is brewing, however, over how to split the loot.

Recently, the Canadian Generic Pharmaceutical Association (CGPA) released a report on the "risks" associated with "tendering" to achieve lower generic drug prices.

Here's the context: Canadians pay unnecessarily high prices for generic drugs. Our prices are set as a percentage of the equivalent brand name drug. Ontario currently prices at 25 percent — the lowest in Canada — yet still pays far higher prices than most countries, adding $245 million to the province's annual drug bill. Nationwide, this figure likely exceeds $1 billion.

In June, Canada's provincial Premiers started remedying this problem. They proposed having generic firms compete to supply provincial drug plans, as is done in other countries. The resulting contracts, or "tenders," would unquestionably lower generic drug prices.

Competitive prices mean tighter margins for pharmacies and generic manufacturers, so the CGPA opposition comes as no surprise. But how solid are their arguments?

The first "risk" in the CGPA report addresses patents. Our laws require generic firms to invalidate all the patents on a branded drug in order to get Health Canada approval. Many branded manufacturers exploit this rule by filing many patents — some of questionable validity — to extend patent protection for their drugs. The report argues that inflated generic prices support the costs of this litigation. Because tendering lowers prices, they argue it would reduce the incentive for generic firms to challenge weak patents, and thus, delay generics coming to market.

We need only look south of the border for a better system. The U.S rewards the firms that challenge patents by granting them a six-month period of market exclusivity — a targeted prize that induces litigation. This and other viable alternative policies are simply not presented as potential solutions in the CGPA report.

The second "risk" listed in the report is that tendering might increase drug shortages. While opponents of tendering have been quick to bring up shortages, they have not properly considered the obligations governments could require in tendering contracts. For example, governments could oblige companies to stock several months of back supply, and require that companies pay all costs associated with securing alternative sources, if necessary.

This is exactly how other countries manage these issues. The CGPA report itself admits that there "have not been any reports of serious supply disruptions in the European Union countries that use tendering."

The third "risk" is that tendering would harm Canadian generic manufacturers. This argument, which seems akin to a request for corporate welfare, conveniently avoids the reality that generic drug production is highly globalized. Only two of nine CGPA member generic manufacturers are headquartered in Canada, and both sell their products in over 60 other countries. We suspect losing a Canadian tender will be far from catastrophic for these firms.

In any case, it appears that Canadian firms could afford to offer more competitive pricing to Canadians. For example, Ontario pays 50.3 cents for amlodipine (10 mg) from Apotex, Canada's largest generic manufacturer. Apotex also lists this drug in New Zealand — a country that uses tendering widely — for 3.4 cents, or nearly 15 times cheaper.

The final "risk" concerns the viability of community pharmacies. On this count, Canadian experience speaks volumes. When Ontario reduced generic prices in 2010, pharmacy chains claimed it would result in closures. The government went ahead anyway, and the number of pharmacies in Ontario continues to increase. Back then, Canada had 40 percent more pharmacies per capita than the United States, and now we have even more.

So, where does this leave the Canadian taxpayer?

Right now, our governments are dumping hundreds of millions of extra dollars into a dysfunctional system and hoping for the best. It would be cheaper, more effective and more transparent for our governments to employ tendering to secure timely and affordable drug supplies.

Ironically, the CGPA report authors, Aidan Hollis and Paul Grootendorst, are on the record supporting tendering. In a 2011 report that wasn't paid for by the generic drug industry, they stated, "We recommend continued experimentation with tenders for generic drugs."

We couldn't agree more. Our pricing system for generic drugs is fundamentally broken. Canadians need access to generic drugs at fair prices, not manufactured anxiety based on one-sided arguments.

The "risks" of tendering are predictable and manageable. It's time Robin Hood gave more to Canadians, and kept less for his merry men.

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Prescription drug addiction is a major public health crisis

More than a dozen Canadians die each week because of accidental prescription drug overdoses

Irfan Dhalla and David Juurlink

The Nov. 19 announcement by federal health minister Leona Aglukkaq that she will not interfere with the approval of generic OxyContin is just the latest development in what has become a major public health crisis.

In Canada, overdose deaths involving prescription medications now vastly outnumber deaths from HIV. By some estimates, prescription drug overdoses have killed 100,000 North Americans over the past 20 years. Astonishing though that may seem, these deaths are just the tip of the iceberg. For each one, there are hundreds of people whose lives have been ravaged by addiction to prescription drugs.

Much of this toll involves opioids — painkillers including codeine, morphine and oxycodone, the active ingredient in OxyContin. Closely related to heroin, opioids produce euphoria, are highly addictive and can be fatal at high doses or when combined with alcohol or other sedating drugs. Until the 1980s, physicians prescribed opioids primarily for acute pain (e.g., from a broken bone) and pain

related to cancer. But today, opioids are more commonly prescribed to patients with chronic conditions like back pain and arthritis, often at doses that would have been viewed as unimaginably high just 25 years ago.

When someone has high blood pressure, there is good evidence that prescribing a drug for many years is beneficial. But with chronic pain, the prescribing of opioids for long periods of time (or at high doses) is not supported by good evidence. Comprehensive reviews of the scientific literature suggest that in many conditions — arthritis, for example — the dangers likely outweigh the benefits. Nevertheless, aggressive marketing by pharmaceutical companies has convinced hundreds of thousands of physicians that long-term treatment with opioids is safe and effective, with little risk of addiction. Some aspects of this marketing campaign have been so misleading that in 2007, the manufacturer of OxyContin pleaded guilty in United States federal court to felony charges of "misbranding" and was fined $634 million.

OxyContin was designed so that the active ingredient would be released in stages over 12 hours, but the controlled-release mechanism was easy to defeat. People seeking a quick high could simply chew the tablets or crush them. For this reason, the manufacturer of OxyContin withdrew the drug from the Canadian market earlier this year and replaced it with OxyNEO. (It is worth noting that this move has also allowed the manufacturer to continue to sell its product at brand name prices for many more years.) OxyContin and OxyNEO have the same active ingredient, and when swallowed whole the two drugs are considered equivalent. OxyNEO, however, is more difficult to misuse because it is harder to crush or dissolve.

All opioids — not just OxyContin — can be misused, and the federal health minister is correct when she says that the law does not permit her to withhold approval of a generic formulation just because of the risk of misuse. But when the legal and regulatory framework results in a situation in which more than a dozen Canadians die each week because of an accidental prescription drug overdose, that framework needs to be changed.

How can we start to undo the damage? A critical first step is to acknowledge the extent of the problem, recognizing that for every celebrity death (Heath Ledger and Derek Boogaard, for example) there are thousands whose deaths do not make the front page. The misuse of prescription drugs and addiction remain taboo topics in our society. This must change. And while recognizing that untreated pain also remains a problem, it is time to stop heeding pleas for continued unfettered access to prescription opioids.

Physicians should re-evaluate how freely we prescribe these drugs for chronic pain, how readily we increase the dose, and we must abandon the widespread perception — implanted in our psyche over many years by the pharmaceutical industry and its agents — that opioids are safer and more effective than other pain relievers. We now know otherwise. Finally, we must become more comfortable treating patients who have become addicted to prescription drugs.

Governments at all levels also need to collaborate on a coordinated national approach. The federal government should pass a law requiring that all opioids be manufactured in a manner that makes them difficult to tamper with. It should also review whether opioids are being marketed for too broad a range of problems. Provincial governments should do their part too. For example, they need to move far more quickly in developing online databases so that physicians and pharmacists can see whether their patients are trying to acquire opioids from multiple prescribers.

We don't need generic OxyContin in Canada. The federal government should still try to find a way to keep it off the market. But more importantly, governments at all levels need to work with doctors to do more to reduce the number of overdose deaths and the burden of addiction to prescription drugs.

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Caution this “Movember”

Prostate cancer screening not backed by good evidence

Alan Cassels

It’s Movember, and the kickoff to prostate cancer charitable activities of all stripes begins in earnest, where we’ll be surrounded by recommendations from charities, doctors and media to get screened for the disease.

Last summer, I was asked if I would debate a prominent urologist in Vancouver over the value of the PSA test, a simple blood test to determine a man’s risk of having prostate cancer. This was what I’d been waiting for. I had just published *Seeking Sickness*, a book about medical screening, and I was eager to see if anyone could step forward and publicly argue against what I was saying about PSA testing — which I think is a bad idea.

Not to mention that I have liked to debate since my days in Military College, where we debated wearing capes.

Having studied the research behind the PSA test, I concluded that the PSA test is a dud.

Yes, it is true that prostate cancer is a condition that kills about three percent of the male population, so it would seem to make sense to employ a “screen early and screen often” mentality.

The main problem with looking for cancer with a PSA test is that the test finds evidence of cancerous cells in the prostates of most men who are getting to be a certain age (I won't say old).

Changes to our prostate cells are not rare at all, and come as naturally to older guys as wrinkles and grey hair. While we'd all like to avoid the rare and rapidly fatal form of prostate cancer, the PSA test mostly finds the slow-growing type that will never go on to hurt us. Yet usually if a "high" PSA score is found, doctors and patients strong biases are to treat the cancerous cells.

Physician and author Dr. Gilbert Welch is an expert on cancer screening and calls PSA testing "the poster child for over-diagnosis." He estimates that nearly two million American men have been unnecessarily treated for prostate cancer — treatment that leaves as many as 40 percent of them incontinent or impotent. As one doctor told me: "a PSA test won't let you live longer, but your life will feel longer."

Nevertheless, my research on PSA tests found that there are still many players in the game promoting the test, especially some of those individuals and organizations with arguably vested interests or much at stake: some urologists who do prostate surgery, radiation therapists who apply the radiation, drug companies who supply treatments and organizations who try to raise prostate cancer awareness.

The largest prostate cancer awareness group in the U.S. gets financial support from some of these groups and is even supported by Depends, the company that makes adult diapers.

Yes, many raise money for these charities in good faith, because they appreciate what men diagnosed with prostate cancer endure and want to improve their quality of life. Fair enough. Just make sure your favoured charity is not encouraging a test that can often do more harm than help, and supplying men with balanced information before asking them to take the test.

But back to the debate. The urologist and I were supposed to meet for a taped TV debate. Finally someone was willing to step into the ring with a little punk like me!

And then he bailed.

The reason given, I heard from the organizers, was that he didn't want to see an upstart get publicity for his book and its message. He's probably right: If people read independent analyses of PSA testing they'd come away with a different picture of the test than what many urologists and cancer charities put forward.

My skepticism around the PSA test was vindicated earlier this year when a respected group that provides "gold-standard" independent analyses of screening, the United States Preventive Services Task Force (USPSTF), announced that healthy men should not be screened with a PSA test, pure and simple.

There's plenty of money to be made from telling men that they have disease lurking in their bodies, and the PSA is a classic case of this. Offering a screening test to a perfectly healthy person demands that we supply a good answer to the question: What if the treatment is worse than doing nothing?

Was that the question that scared my opponent off? Maybe he backed out because someone told him I was going to wear a cape.

Alan Cassels is an expert adviser with EvidenceNetwork.ca and a drug policy researcher at the University of Victoria. He is the author of the new book, Seeking Sickness: Medical Screening and the Misguided Hunt for Disease *[Greystone, 2012]. He is still willing to debate any urologist on the value of the PSA test.*

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Generic drug prices in Alberta

A step in the right direction

Michael R. Law and Jillian Kratzer

Want to buy a $100 coffee?

Sounds absurd, doesn't it? However, it's equally absurd that this is how much more Albertans pay for some generic drugs than people in other countries.

Take, for instance, 20 mg of the cholesterol-lowering drug simvastatin. Albertans pay 90 cents for each tablet. In New Zealand, the government drug plan buys the same drug for 1.8 cents, or 50 times cheaper. And simvastatin is not alone: Albertans currently pay more than other countries for 93 percent of widely used generic drugs.

The good news for Albertans is that some relief is coming. In this month's budget, the government reduced their maximum price for generic drugs from 35 percent of the equivalent brand name drug to 18 percent. In effect, this means they cut prices in half, and will save $90 million every year as a result.

This is a positive move for two reasons. First, it will make life easier for the one in 12 Albertans that currently can't afford their prescription drugs, and also benefit Alberta's employers by significantly

reducing their employee benefits costs.

Second, it will save money that is being unnecessarily spent from public coffers. Across Canada, provincial governments are spending hundreds of millions of dollars more than they would at international prices every single year. This move will put some of those funds back into the public purse.

A dollar saved, of course, has to come from somewhere. And thus, pharmacies and generic drug manufacturers have voiced their entirely predictable objection to this move.

Pharmacies have claimed that the loss of revenues from Alberta's move will lead to reduced access to pharmacy services. We need only look across the country to find strong evidence that this is not the case. In 2010, Ontario also halved the price of generic drugs. Back then, pharmacy chains in Ontario claimed the price cuts would force them to close outlets. In reality, the number of pharmacies has increased in both years since the change. The Alberta government has also increased the funding for pharmacy services and rural pharmacies to help this transition.

Generic drug manufacturers have rightfully pointed out Alberta could benefit from using generic drugs more often. While 80 percent of prescriptions are for lower-cost generics in the United States, they are just 60 percent in Canada. However, what they neglect to point out is that you will save even more if you buy them at a fairer price.

The real question isn't whether Alberta should go forward with this move. The evidence is clear that they should.

The real question is what Alberta should do next. Our answer: introduce true competition into this market.

You see, other countries obtain lower prices by getting generic manufacturers to compete against one another to offer a high-quality product at the best price. That's how New Zealand gets simvastatin at such a great price.

Other generic drugs used by hundreds of thousands of Albertans are also purchased in other countries for a fraction of the price. Even at the new 18 percent prices, Albertans will still pay 14 times more for atorvastatin, 11 times more for amlodipine, and five times more for metformin. These are not cherry-picked examples: even with Alberta's change, the prices available in other countries will still be lower for 82 percent of commonly used generic drugs.

Other nations can provide a wealth of experience with competitive contracts: this is how public drug programs in the U.S., New Zealand and a number of European countries buy generics, and how they ensure a secure and stable supply of medicines. The claim that lower prices will result in drug shortages is simply not based on evidence: even a report commissioned by Canadian generic manufacturers found that European countries using competition have not experienced drug shortages as a result.

Alberta should seize the opportunity to become a true national leader. The province should couple lowering prices with improving drug coverage. Instead of just lowering prices, the government should use this opportunity to introduce universal coverage — Medicare coverage — for some widely used generics for chronic conditions like hypertension and diabetes. The beauty of such a policy is that it would improve health and save money at the same time. It would be a win-win for Albertans, and an example for the rest of Canada.

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Moving to income-based drug coverage is the wrong prescription

Steve Morgan

The Alberta government has announced major pharmacare reforms: the province is planning to move from a system where public drug coverage is available mainly for seniors to a system where coverage will be restricted based upon income. Experience from other provinces suggests that income-based pharmacare will not pan out well for Albertans.

In an upcoming paper with the C.D. Howe Institute, my colleagues and I review evidence on pharmacare options available in Canada and abroad. One of the options we review is income-based pharmacare, which the government of British Columbia adopted a decade ago. That system, while successful in reducing public drug costs, has produced unforeseen consequences that call into question the overall success of such reforms.

All good drug plans must ensure access to necessary medicines. At a recent national symposium, experts from the pharmaceutical industry, government, patient groups, health professions and academia ranked this as the number one goal for pharmacare in Canada.

The trouble with income-based pharmacare is that it doesn't deliver on this essential goal because individuals must spend considerable sums on medicines before public benefits kick in. Evidence

shows that out-of-pocket charges prevent people from filling medicines that can improve their health, which would keep people out of doctor's offices and hospitals — saving money to the overall public healthcare system.

Studies of British Columbia's move to an income-based drug program found that seniors' access to essential medicines fell and their use of other healthcare services increased. And contrary to claims, no studies have shown income-based pharmacare improved non-seniors' access to medicines in British Columbia.

Just like medicare policy more generally, pharmacare policy should also aim to protect citizens against the financial consequences of an unforeseeable illness. This is where income-based pharmacare falls short — ironically so, given that these programs are pitched as a "fair" way to provide drug benefits.

Income-based pharmacare is an "insurance" solution that is suitable for protecting people against random, one-time losses, such as having ones' home burn down. But drugs are different than most one-time healthcare interventions — most drug prescriptions are for repeated, long-time use, where an ill patient requires ongoing treatment.

Data from British Columbia show that prescription drugs required by the sickest 20 percent of the population account for 80 percent of all drug costs. Whether young or old, these people typically require significant pharmaceutical treatments year after year, often until death. Asking chronically ill people to pay a given percentage of their incomes toward their medicine needs year after year is tantamount to taxing them for their poor health.

Because health generally deteriorates with age, most seniors live with chronic needs for medicines. They can therefore expect to bear the financial burden of deductibles under an income-based pharmacare program. Given that fewer employers are offering retirement health benefits — because doing so with an aging workforce will put individual employers and their workers under significant financial strain — retirees can't rely on employment-related insurance to help defray drug costs.

The Alberta government has announced that an income-based universal plan will save $180 million annually by 2015. But is that really cost savings to Albertans or cost-shifting, meaning that sick Albertans will still need to pay for those costs but instead, do so privately?

While British Columbia's income-based pharmacare program dramatically reduced government spending on prescription drugs, total prescription drug costs didn't fall. Instead, they grew more rapidly than before. Patients, particularly the elderly, and the employers and workers who fund private insurance plans had to pick up a larger and faster growing share of drug costs as a result.

Income-based pharmacare will not improve access to medicines. It will effectively tax the sick. And it will take away incentive and opportunities to better manage this critically important component of the healthcare system.

Albertans would be far better off if government expanded, and not contracted, public drug benefits. Virtually every healthcare system that is comparable to Canada's shows that doing so would not only improve access and financial protection, but would also reduce system-level expenditures dramatically.

But other countries' governments have arguably done better in making the case to the electorate that they would be better off by expanding public health drug coverage. A very small increase in income

taxes today could fund a broader drug program that would improve access, which would help reduce hospital visits from unfilled prescriptions. It would protect Albertans from the unforeseen private costs should they fall ill. And, most importantly, it would result in lower overall costs and especially lower costs to employers — and hence, higher wages — in the future.

For these reasons, Albertans should demand that pharmacare be expanded and made better rather than be contracted and made worse.

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Our pharmacare system in Canada is designed to fail — and it's costing us billions

Steve Morgan

Another budget cycle has passed without remedy for the biggest unresolved problem in our healthcare system. From 1980 to 2010, spending on pharmaceuticals used outside of hospitals in Canada grew more than 15-fold, from just under $2 billion to just over $30 billion. Yes, billion.

In contrast, spending on healthcare covered under the Canada Health Act — hospital care, including drugs used in hospitals, and medical care provided by physicians — grew just over five-fold during the same period, from $12 billion to $83 billion.

Part of the reason that pharmaceutical spending has grown so rapidly is that waves of new drugs have come to market since the 1950s that allow us to treat an ever expanding range of medical conditions — and that's mostly a good thing. In many instances, pharmaceuticals are unquestionably the most cost-effective way to treat a patient.

But much of the growth in pharmaceutical costs in Canada results from the perverse structure of our health system. Canada is the only country in the world that offers universal health insurance for medical and hospital care but not for prescription drugs. Instead, we have a patchwork of private and public plans that effectively leaves nobody holding the reins of this important component of healthcare.

Our fragmented system of drug coverage means that many Canadians cannot afford the medicines they need. Research published last year in the *Canadian Medical Association Journal* showed one in 10 Canadians report that they skip doses or decide not to fill prescriptions because of cost. By international standards, that is a very poor record on access to medicines.

Yet, by international standards, spending on pharmaceuticals in Canada is extraordinary. Our drug costs are higher and faster growing than all other countries in the OECD with the exception of the U.S. — hardly an admirable comparison.

Canada does have regulations that limit list prices of patented medicines to the median of prices found in seven comparator countries: France, Germany, Italy, Sweden, Switzerland, U.K. and the U.S. But such price controls, unfortunately, do not result in expenditure control.

In the late 1980s, when our price regulations first came into effect, per capita pharmaceutical spending in Canada was below the median of our seven comparator countries — we were doing pretty well. But our spending was growing more quickly than in other countries and continued to do so. By 1997, our level of spending had caught up to the median of our comparator countries, placing us squarely in the middle of the pack. Turns out, those were the good old days.

In 1997, the National Forum on Health called for a universal pharmacare program in Canada. They recommended this as a means of improving access to care and better controlling costs.

We did not move forward on that recommendation. Since then, per capita pharmaceutical spending in Canada has continued to outpace comparator countries, so much so that, as of 2010, we spent $280 more per capita than the median of our comparator countries.

To put this in perspective, if we had implemented a pharmacare program in 1997 that controlled our drug spending so that it continued to grow, but only at the same rate as our comparator countries for drug price regulation, we would be spending $9 billion less per year than we are today. That's enough to finance the 42-year life cycle of the F-35 fighter jets in just five years!

Our fragmented system of prescription drug financing is the root cause of our troubles.

When pharmaceuticals are integral to healthcare financing and management — as they are in all universal healthcare systems comparable to ours — system managers and, importantly, practitioners have more incentive and opportunity to manage costs. They have better incentives to consider the value for money spent on new drugs versus older ones, and on drug therapy versus other forms of care. And they also have more purchasing power in price negotiations with drug manufactures.

Not recognizing that our pharmacare system (or lack thereof) is designed to fail is costing us billions of dollars every year while many Canadians go without access to the medicines they need. We deserve better. We deserve a medicare system that includes prescription drugs and thereby delivers the access and efficiency found in all other countries with healthcare systems comparable to ours.

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We need more “real world” research on pharmaceutical drug safety

Statins research by federal drug safety watchdog makes international headlines

ALAN CASSELS

Pharmacovigilance. It’s a fancy word, but means a very simple and important thing to all of us — it’s about keeping a watch (being vigilant) on the safety of the pharmaceutical supply. Researchers in this area try to find signals from large data sets, looking for adverse drug reactions which point toward better and safer ways of using drugs.

Ever since the Vioxx debacle of a decade ago, when one of the biggest selling drugs in the history of the world came crashing down after it was shown to cause heart attacks and deaths, there has been a huge demand for stronger levels of pharmacovigilance in this country.

Luckily, Canada’s federal government responded, too slowly and with too few dollars, but at least the creation of the Drug Safety and Effectiveness Network about five years ago was a start. Finally we had a home-based network of Canadian researchers doing solid pharmacovigilance research in this country, carrying out the kind of serious drug safety evaluation we desperately need.

For proof of concept, a DSEN study published on March 19 in the *British Medical Journal* found that people taking higher strength statins (drugs to lower cholesterol, like Lipitor, Crestor or Zocor) face an increased risk of kidney injury. It found that patients on high potency statins were more likely to be hospitalized for acute kidney injury within 120 days of starting treatment compared to those taking low-potency statins.

This class of drugs has been under a dark cloud for a long time, especially due to the muscle-weakening, and cognitive effects that people in the “real world” (that is, outside the bounds of clinical tri-

als) experience. That's why real world research is so valuable — it can measure through large administrative data sets what kind of experiences people can have.

The absolute risk of kidney injury seemed small (about one in 275 high-dose statin patients were hospitalized for acute kidney injury, versus one in 375 for those on low-dose statins) but when you consider the millions of Canadians swallowing a statin every day, the overall number harmed is likely large.

This study again reminds us that taking a drug for one thing (lowering cholesterol) can have consequences of doing other, unexpected things (injuring your kidneys). Kidney damage can be profound and devastating, which is a high price to pay for someone who is otherwise perfectly healthy, but told by their doctor they need a drug to lower their cholesterol.

Over the years, real-world experiences of statins have started to seep into general practice, largely by those who report adverse drug reactions such as nagging muscle weakness and pain. Since about a third of statin users are taking higher potency statins, we now have some credible proof that more people are being harmed than need be.

The Canadian researchers who did this work looked at health records of two million patients in Canada, the United States, and the United Kingdom, essentially sifting through an enormous pile of anonymous patient data to find drug safety signals that would be impossible to do in smaller trials or epidemiological studies.

We can feel good that we've got strong federally funded pharmacovigilance studies in Canada producing results such as these. All, however, is not rosy, especially when you consider how political drug safety evaluation work can be. And how threatening it can be to the pharmaceutical industry.

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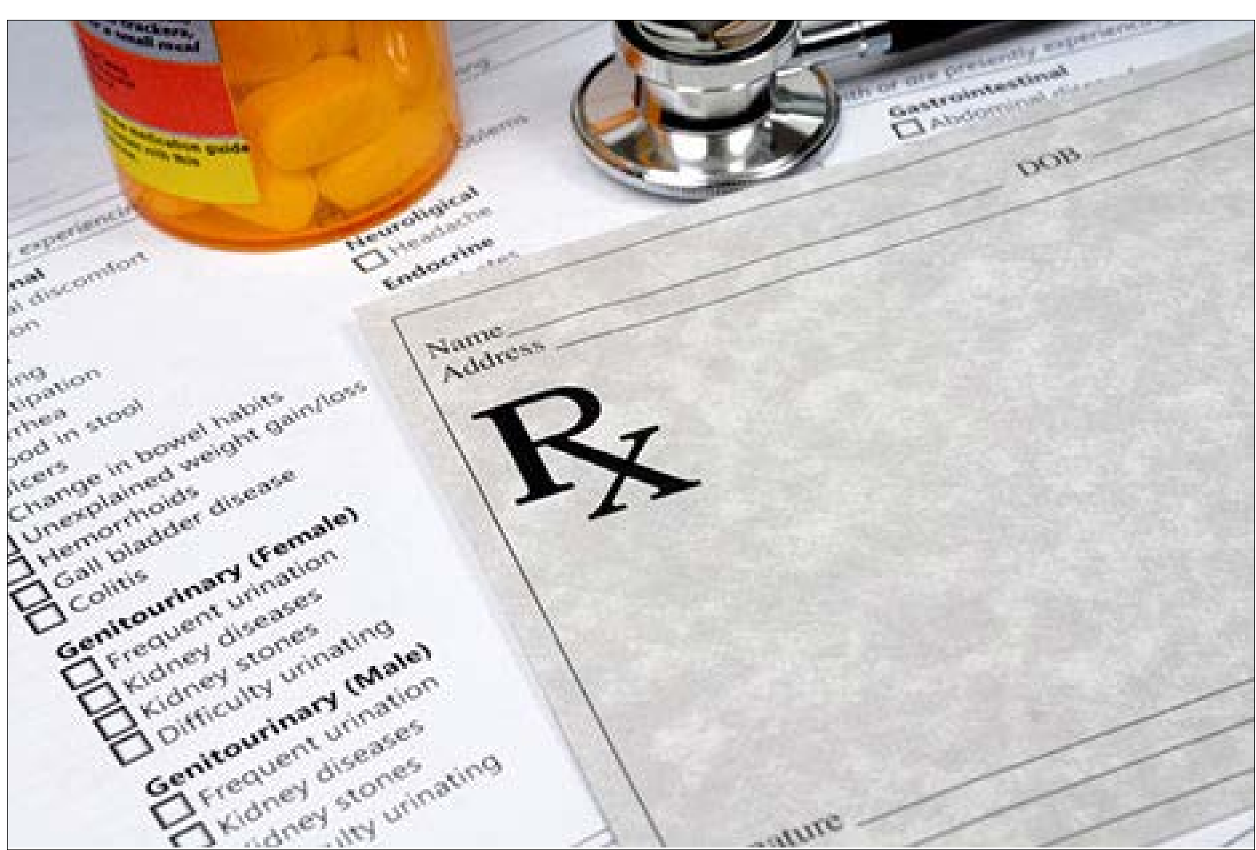
Beware drug store dispensing fees

Why it's worth shopping around for your pharmaceutical drugs

Noralou Roos



Ever wonder why we have so many pharmacies around town? It seems as if there's a new one on every other street corner these days. Some of them seem to have found all sorts of ways of making money from the unwary consumer.

Just last week I went in to my local pharmacy with a prescription for a year's supply of a low dose thyroid medication that I've been taking since I was in high school. As usual, I asked my doctor for a prescription for one year's worth of pills. After all, I'm healthy, and I don't need to visit her more than once a year to monitor this condition. It saves everyone time and money, right?

I've been doing this for several years now, stocking up with a yearly trip to the pharmacy instead of costing our health system repeat visits to the doctor for smaller prescriptions, and occupying her time, which could be spent seeing patients actually in need of her attention.

This year was a different story when I decided to try a new drug store. I cordially handed over my prescription for a one year supply of pills. Yes, I anticipated the usual sales pitch where they try to get you to buy your pills in one month increments (thus charging you 12 "dispensing fees" instead of one). So I was surprised when the pharmacist, a nice lady with a firm voice, had a new line: "No,"

she said, “I’m sorry, but the maximum I can give you is a three month supply.”

She made this sound like a law, like health policy written in stone. We debated this a bit and went back and forth. I even pointed out I was given a one year’s supply last year at a competing pharmacy. Finally, she went away and came back with a final verdict: “No, we can only give you a three month’s supply — that is all Pharmacare allows.”

She assured me I could come back in three months for the next set of pills. Reluctantly, I agreed and paid my bill and left the store. It was only when I got home that I discovered I had paid the same dispensing fee for a three-month supply as I would have for a one-year supply. Turns out, it doesn’t matter if you get 10, 100 or 365 pills — the pharmacy charges the same fee for each visit.

In other words, pharmacies have every reason to encourage you to purchase a few pills at a time and to refill frequently.

Dispensing fees are not created equally either. The dispensing fee cost varies widely from pharmacy to pharmacy — and all you have to do is phone and ask. I did a random sample in my neighbourhood and found that the Shoppers Drug Mart charged the highest dispensing fee at $13; Rexall was close at 11.99; Loblaw was $10.10, and even Walmart charged $9.97. Costco only charged $4.49 for dispensing (though you require an annual membership to shop there).

Incidentally, I called Manitoba Health and asked if Pharmacare puts any restrictions on how many pills a drug store can dispense. Apparently there is a 100-day limit — but it applies only if the payer (those paying for the medication) is Pharmacare, and some insurance companies have a similar limit.

If you are the sole payer for your prescription drugs and you aren’t expecting to be reimbursed for your drug purchase, you can fill a 1,000 tablet prescription at one time — there’s no limit. One has to wonder why insurers are sitting back and encouraging these extra dispensing charges to be billed. Why not allow those on long-term medications to have one time annual fill ups? (Of course, if you have a condition that requires regular monitoring or if the drugs are new for you, regular consultations with the doctor and pharmacist are a good thing). It looks like we need to become better consumers when buying our prescription drugs.

The bottom line: Call around and find out which pharmacy in your neighbourhood has the cheapest dispensing fee. And if they push you to take a supply which would mean having to come back to them for repeated refills, simply say “no thanks.”

Who needs extra trips to the doctor or the drugstore? Every time you pick up more pills it helps fill the cash register at the pharmacy and empties your pocket. That pharmacy fee, which will be added on every time you come back, might be better spent elsewhere. After all, there are plenty of good new movies out there.

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Drug marketing may be bad for your doctor (and even worse for you)

Toxic information

ALAN CASSELS

It sometimes takes a long time to discover environmental hazards, and even longer to do something about them, once discovered.

The dangers of second-hand tobacco smoke, leaded gasoline and asbestos were all deemed bad for our health many years ago, yet the lag between discovering those hazards and doing something to eliminate them took many years and cost many lives.

On April 5, a study concerning the world of prescription drug information identified a new and potentially deadly hazard: the pharmaceutical sales rep visit. This study, published in the *Journal of General Internal Medicine* and carried out by researchers in Canada, the U.S and France, asked the question: When a drug sales rep has a private one-to-one conversation with a doctor, what kinds of drug information do they actually receive?

If you've ever seen the well-dressed men and women with iPads and nice shoes in your doctor's waiting room, you'll know what a drug sales rep looks like. Working on behalf of pharmaceutical

companies, they visit our doctors on an individual basis, often dropping off free samples of medications, talking up the company's products and otherwise schmoozing our physicians, often promoting the newest and most expensive medicines.

This form of marketing is common in most countries, yet it has largely escaped close research scrutiny. It's also very big business. Drug sales reps and the samples they drop off consume more than two thirds of the estimated $2.5 billion that the drug industry spends on drug marketing and promotions in Canada every year.

You might say, what's wrong with companies spending money on sales visits and free samples? Isn't this a good way for our doctors to discover new products and become well-acquainted with the latest medicines?

Unfortunately, the opposite might be true. The study released this week found that the one important piece of information physicians need — information on the potential harms or adverse effects of newly promoted drugs — is usually missing from the sales encounter.

The study found that in nearly 60 percent of promotional visits, sales representatives failed to provide any information about common or serious side effects of the promoted drug, and also failed to explain the types of patients who should not use the medicine.

In Vancouver and Montreal, two thirds of the promotional visits had absolutely no mention of a drug's potential harmful effects.

Probably most worrisome is that across all three countries, serious drug harms were mentioned in only six percent of the promotions, even though more than half of the medications being promoted in these office visits were drugs that came with a U.S. Food and Drug Administration "black box" or Health Canada boxed warnings — warnings that are reserved only for the most serious and potentially fatal drugs.

Barbara Mintzes, an expert in drug advertising at University of British Columbia and a lead author of the study, said she's concerned that such a situation leaves doctors and patients in the dark and can seriously jeopardize patient safety. Despite laws in all three countries requiring sales representatives to provide information on the potential harms as well as the benefits of drugs, she says, "no one is monitoring these visits and there are next to no sanctions for misleading or inaccurate promotion."

The study reinforces the conclusions of a recently published systematic review of a wide body of international research showing that physicians who are exposed to more drug-company-sponsored information tend to prescribe costlier drugs, more drugs in total and to have lower quality prescribing practices.

This earlier study examined all the research in the area and failed to find net improvements in prescribing practices resulting from drug-company visits. Instead, they recommend that physicians "follow the precautionary principle and thus avoid exposure to information from pharmaceutical companies."

This might be the take-home message for the new three-country study as well. All medicines can cause harm as well as benefit and doctors need to know about both. Incomplete information on a drug's safety is likely to lead to harm, akin to an environmental toxin.

So, now the real question is: how long will it take before public authorities determine people are

being harmed? And what regulations will they put in place to make sure our physicians receive balanced information about the benefits and harms of our pharmaceutical drugs?

Alan Cassels was a collaborator on this research study. He is an expert adviser with EvidenceNetwork.ca and a pharmaceutical policy researcher at the University of Victoria. He is the author of Seeking Sickness: Medical Screening and the Misguided Hunt for Disease.

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Who's afraid of universal pharmacare?

How a pharmacare program would use market forces to Canadian benefit

Marc-André Gagnon

Canada is one of the world's most expensive countries when it comes to prescription drugs. Per capita, prescription drug costs are on average 50 percent higher in Canada and they have had the fastest yearly growth in the last decade compared with other developed countries.

Why is this the case?

Canada is one of the rare developed countries in the world without universal pharmacare, and we are the only country in the world with a universal medicare system that excludes prescription drugs (as if pharmaceuticals are not an essential element of medical treatment).

A staggering 10 percent of Canadians each year cannot fill a prescription due to financial reasons.

Canadians understand the gaps in our current system and want them addressed. An EKOS poll released recently shows that 78 percent of Canadians support the implementation of a universal pharmacare program.

In early June, economist Yanick Labrie from the Montreal Economic Institute criticized a conference I co-hosted on universal pharmacare in Ottawa, and published the report "Wrong Prescription"

against cost-containment measures for prescription drugs. Labrie argues that a national drug plan would be bad for Canadians because it would reduce drug costs, thus reducing spending in research and development for new drugs and increase drug shortages. Private drug plans are touted as solutions because they offer more "generous" coverage.

Mr. Labrie should have attended the conference where he would have heard each of these arguments discussed and refuted in turn.

More than 80 percent of new drugs entering the market today do not represent any therapeutic advance compared to existing, cheaper drugs. If we have drug plans reimbursing any new drug, whatever the cost, and even when there are cheaper, equivalent drugs available, do we really provide incentives for drug companies to invest in breakthrough innovation? In fact, the opposite occurs: we give them a huge incentive to bring to market reformulations of existing products.

The pharmacy benefit management company Express Script Canada estimates that private drug plans waste $5.3 billion in reimbursements for drugs that do not provide any additional therapeutic benefits compared to existing formulations. This amount represents 56 percent of total money spent by private drug plans. At our conference, an executive from Great-West Life explained that in their current form, private drug plans are not sustainable. However, it is these wasteful, inefficient and unsustainable drug plans that are touted as the main solution by the Montreal Economic Institute.

In contrast, the universal pharmacare system in the United Kingdom employs market forces in an ingenious way. Through value-based pricing, drug companies get paid according to how much they improve the health outcomes of the population. This creates formidable market incentives for drug companies to focus on therapeutic innovation instead of lavish promotion and copycat drugs.

But would a bulk-purchasing agency for generics create more drug shortages because of lower prices, as Labrie argues? Canada is one of the world's most expensive countries for generics and we pay, on average, twice as much for the same generic drug in Canada as the United States. Following Labrie's logic, because we pay more Canada should be less afflicted by drug shortages than countries with universal pharmacare and bulk-purchasing capacities. In fact, we observe exactly the opposite pattern.

Countries that have introduced bulk-purchasing powers use their buying clout to make sure tenders on specific drugs include clauses to avoid the possibility of drug shortages. In an era of global mergers and acquisitions and growing concentration among generic manufacturers, bulk-purchasing is another smart way to use market forces to decrease costs and ensure stable supply.

When it comes to prescription drugs, Canada's current system is plagued by massive waste, massive costs and plenty of people unable to afford their drugs. Universal pharmacare does not mean an "open bar" for everybody, it means leveraging buying power and using market forces in order to contain drug costs, achieve sustainability and improve the health outcomes of the population.

Economist Bob Evans recently described the main obstacle for the implementation of universal pharmacare in Canada: "Anyone's spending is somebody else's income. Universal pharmacare could save billions to Canadians, so there are powerful corporate interests that will do everything they can to make sure it does not happen."

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A version of this commentary appeared in the *the National Post, the Yukon News*, and *the Huffington Post*.

Canadian medicare needs an Rx

78 percent of Canadians support coverage of medically necessary prescription drugs

Steve Morgan

Polls show that most Canadians cherish the underpinning ethics of our medicare system: that healthcare should be allocated on the basis of need, not ability to pay. But polls also show that Canadians want more from the system.

The list of potential improvements is long. Public opinion and research evidence point to areas such as improving primary healthcare, reducing wait times and being more proactive about health promotion and disease prevention.

One health system improvement seems to be capturing increasing attention of the public, health professionals, unions, employers and experts. It is to make medicare more comprehensive by expanding coverage to include medically necessary prescription drugs.

A poll released on May 22 by EKOS Research Associates found that more than three-quarters (78 percent) of Canadians would support expansion of public drug coverage to make "Pharmacare" in Canada operate like our medicare system.

Canadians have good reasons to want such reform. Every developed country with a universal health-

care system provides universal coverage of prescription drugs…except Canada.

Drug coverage is provided in all comparable healthcare systems because, when prescribed and used appropriately, prescription drugs can be among the most cost-effective forms of providing healthcare. The architects of these other systems know that charging patients for prescriptions will impede the use of essential medicines — which can cost the healthcare system in other ways, such as increased hospitalizations.

In Canada, many patients cannot afford to take medicines prescribed by their doctors. The recent poll by EKOS suggests that, in the past five years, about one in five Canadians (23 percent) have chosen not to fill a prescription because of out-of-pocket costs. That's a lot of missed prescriptions.

Such access problems are prevented when medically necessary prescriptions are covered as part of the healthcare system. Countries with such access — every other developed country with universal healthcare — also spend considerably less on pharmaceuticals than Canada does. This is because healthcare systems that purchase medicines on behalf of entire populations have significant bargaining power in price negotiations with drug manufacturers.

Managers and prescribers in such systems also have incentives to view medicines as part of healthcare as whole. Allowing high prices or over-prescribing ultimately reduces resources available for other forms of patient care because costs cannot simply be passed onto patients, employers, unions or other actors — as is too often done in Canada by way of reduced drug coverage, increased patient charges or increased insurance premiums.

The United Kingdom provides a good example of integrated health and pharmaceutical coverage. There, the public healthcare system provides universal coverage for medically necessary prescriptions at little or no cost to patients. It works. Citizens of the U.K report virtually no barriers to access — just two percent of the population reports skipping prescriptions because of cost.

Instead of asking patients to consider costs, the system in the U.K asks doctors to do so by connecting prescribing budgets with budgets for medical and hospital care. That works too. Their prescribers rely less heavily on newer, more costly drugs when older treatments might do as well or better.

As a single-payer system, the U.K also obtains much lower drug prices than we do in Canada. Brands are roughly 30 percent cheaper and generics are 30 percent cheaper. Yet, it is worth noting that the U.K attracts more than five times as much pharmaceutical R&D on a per capita basis than Canada.

Put another way, if the per capita costs of pharmaceuticals in Canada were the same as the U.K, we would spend $14 billion less on medicines every year. That is enough to pay annual salaries for 180,000 new nurses in Canada — an increase of our nursing workforce by 50 percent.

Canadians are justifiably proud of the basic structure and ethics underpinning our medicare system. But a growing number of us are realizing that the system is uniquely incomplete.

Pharmaceuticals are integrated into every other universal healthcare system in the developed world. It's time to do the same for Canada. We could begin with clear winners for patients and the health system such as covering drugs to manage cardiovascular risks, diabetes, asthma and severe mental illness.

If we fail to do so we will continue to pay more to get less.

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Fair PharmaCare fares poorly

B.C.'s pharmacare system a catastrophic failure

Steve Morgan

It has been a decade since British Columbia implemented Fair PharmaCare. The program ended what was effectively public provision of prescription medicines for seniors and created an income-based government safety-net for all people, regardless of age.

So how has the program performed?

In a paper published June 13 by the C.D. Howe Institute, my colleagues and I review the performance of Canadian pharmacare models against systems in comparable countries around the world. We find that B.C. fares poorly within Canada, and that Canada fares poorly among comparable countries abroad.

Under Fair PharmaCare, public subsidies kick in only after prescription drug costs surpass three percent of household income. This makes B.C.'s the most generous income-based drug plan in Canada. But before celebrating, consider this: most B.C. households still pay thousands of dollars in annual deductibles, many are not filling the prescriptions they need, and costs to employers, unions and patients have skyrocketed.

What is not well understood is that the vast majority of B.C. citizens receive no benefit at all from the Fair PharmaCare program. And patients who do receive benefits still face considerable out-of-pocket charges for their prescription drugs.

Perhaps worst of all, most people who require high-cost prescription drug treatments will do so year after year, often until death. This is because high-cost prescription needs only occur among people with serious, typically chronic illnesses. The deductibles under income-based pharmacare programs, including B.C.'s Fair PharmaCare, are therefore tantamount to an income tax levied only on people in very poor health. No comparable healthcare system imposes such charges on patients.

Out-of-pocket costs also have an adverse effect on people with more routine medical needs. Time and time again, studies have shown that even small charges will deter patients from filling prescriptions. Because the Fair PharmaCare program does not provide any coverage for people with routine medical needs, it creates a very effective barrier to accessing necessary medicines.

Nearly one in five British Columbians reports that they have been unable to afford medicines prescribed by their doctors. That is double the rate of financial barriers to accessing medicines found in the rest of Canada and 10 times the rate found in the United Kingdom.

The problem with financial barriers to filling prescriptions is that patients often stop taking medicines that prevent them from needing other, more expensive forms of healthcare. This can cost governments more in the long run than what is saved by imposing such charges. For this reason, every other developed country with a universal healthcare system provides universal coverage of prescription drugs at little or no cost to the patient.

Of course, Fair PharmaCare was implemented to reduce government spending on prescription drugs. It sure did! Some estimates indicate that Fair PharmaCare has reduced public spending by $2 billion since its introduction. But that $2 billion is not "savings" to British Columbians. Far from it. Costs have simply shifted off government books and onto employers, unions and patients who fund the now fast-growing private cost of medicines.

In their defence, the B.C. government may point out that the Romanow Commission recommended universal coverage for catastrophic costs in 2002. I know the Commission's recommendations well — I wrote them.

Romanow recommended universal coverage for catastrophic costs as a minimum, short-term standard for public pharmacare programs. Romanow went on to recommend that public drug plans then be expanded to provide universal coverage — at little or no cost to patients — for drugs of proven value for money in the healthcare system.

Though 10 years have passed, it is not too late for B.C. to build a better pharmacare system.

Expanding coverage so that the government ensures access to essential medicines through public provision will improve overall healthcare system performance. It will also reduce financial strains on patients and increases our collective buying power, resulting in lower costs to us all.

Every comparable healthcare system in the world shows that prescription drug coverage can be better, fairer and cheaper for everyone. British Columbians should demand no less of their government in this critical component of the healthcare system.

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Why New Brunswick has to rethink pharmacare

Steve Morgan

New Brunswick is the only province that does not ensure that all citizens are insured, at a minimum, against catastrophic prescription drug costs. For this, the government has received a considerable amount of flack. Unfortunately, the pharmacare systems in other provinces across the country are hardly lofty comparisons.

Every developed country with a universal healthcare system provides universal coverage of prescription drugs… except Canada. Instead, Canadian provinces offer limited public subsidies for prescription drugs for those with the highest needs or those with the lowest incomes, New Brunswick included.

But no province in Canada funds even as much as 50 percent of the total cost of prescription drugs consumed by its citizens. This leaves an extraordinarily high percentage of prescription drug costs in Canada to be paid for directly by patients or through private insurance, for those lucky enough to have it.

In a paper published this week by the C.D. Howe Institute, my colleagues and I review the performance of Canadian pharmacare models against systems in comparable countries around the world. We find that the most costly, inequitable and inefficient systems for financing prescription drugs

are those that diminish pharmaceutical purchasing power, impose considerable charges for drugs on patients and isolate the management of prescription drugs from other key components of the healthcare system.

This is not good news for Canada. The individual "pharmacare" systems in each of our provinces do all of these things.

It's not good news for New Brunswick either because what appear to be the two competing options for reforming the New Brunswick Prescription Drug Program do not necessarily represent progress toward a more equitable and efficient system.

The model that many New Brunswickers believe is right for the province — universal public coverage against only catastrophic drug costs — turns out to be one of the least effective ways of financing prescription drugs. Such a model, exemplified by the system in British Columbia, results in poor access to medicines, provides limited protection against the financial consequences of ill health, and diminishes the government's capacity to control pharmaceutical expenditures.

On the other hand, the model recently proposed by the government of New Brunswick — compulsory insurance based on a private insurance model of drug coverage — is no better. Exemplified by the system in Quebec, such a model will improve access to medicines, making it better than the catastrophic coverage model in this regard. But a system involving insurance-like premiums, deductibles and co-insurance still imposes notable costs on people with chronic medical needs.

Worse yet, financing medicines through a multi-payer system that is isolated from the financing of medical and hospital care reduces administrative efficiency, diminishes purchasing power and creates a "silo mentality" in system management. All of this creates waste that can and should be avoided.

It is time to rethink pharmacare.

Ultimately, the challenge for governments in Canada is to find a way to integrate prescription drugs into our otherwise public healthcare system. The goal would be for decision-makers and healthcare professionals to see prescription drugs as an integral component of overall healthcare. Such a mindframe would encourage use of medicines where cost-effective, and discourage use when other forms of care would be better, safer and cheaper.

Achieving these goals will not be easy but it is becoming evermore imperative.

For New Brunswick, a way forward is to build its compulsory insurance program entirely within government. This would achieve key goals of increased buying power and better integration with the healthcare system.

This new public drug plan would ideally focus medicines of known value-for-money from a health system perspective — drugs that, when used appropriately, unquestionably improve patient health and save money elsewhere in the healthcare system. And, like medicare more generally, it would ideally provide access to such medicines at little or no cost to patients.

Evidence from comparable countries worldwide shows that such a universal pharmacare program would promote access to necessary medicines, protect people from the financial burden of medical needs and reduce total spending on prescription drugs. It would be a win, win, win for the citizens of New Brunswick.

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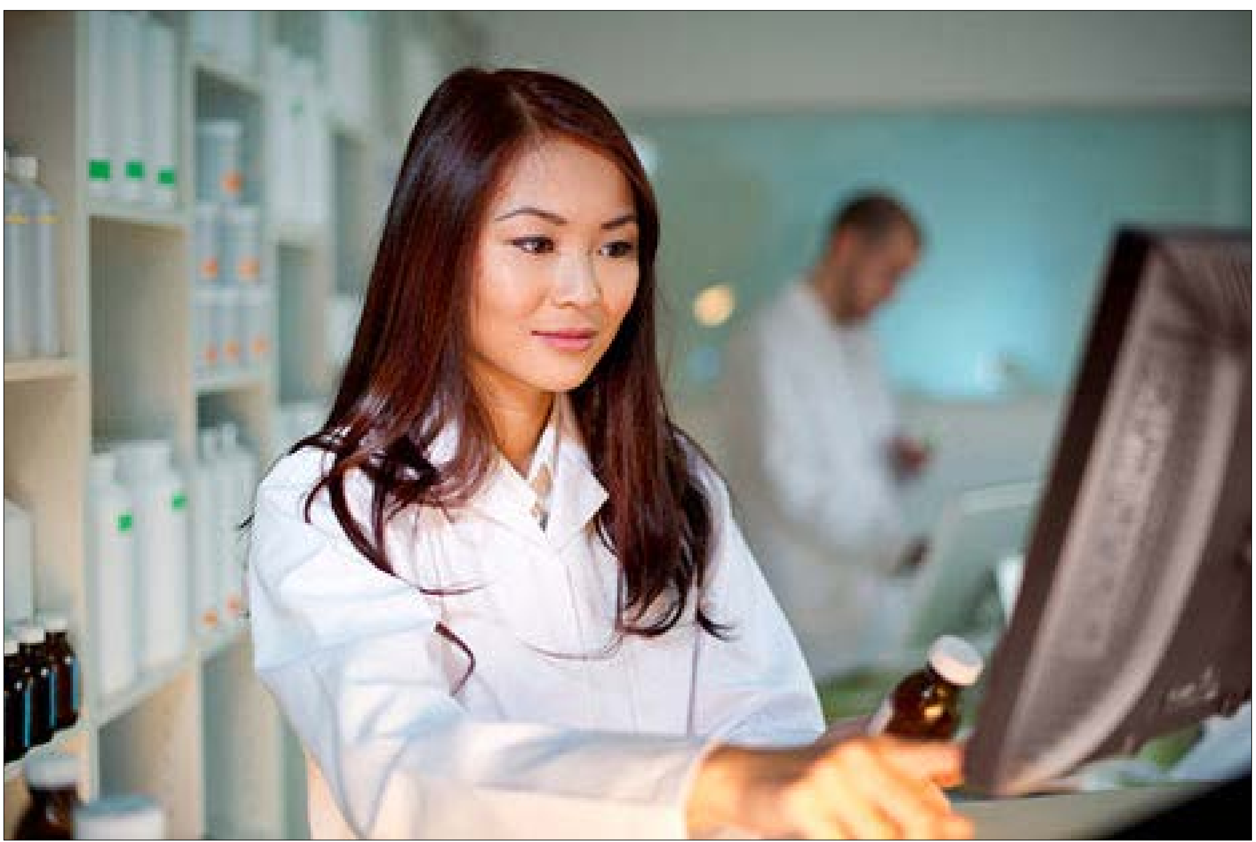
Why Ontario should pioneer the expansion of prescription drug coverage in Canada

New report finds Ontario's pharmacare model wastes billions of dollars annually

Steve Morgan



At a national health policy conference on June 13, Ontario's Health Minister Deb Matthews made a few notable comments. Among them was a request that policy experts applaud government officials when they do the right thing. Too often, good healthcare policy gets blocked by a very vocal minority of stakeholders.

Minister Matthews also said that expanding prescription drug coverage would be a top priority for Ontario if the government had the money to do so. This is great news because my colleagues and I released a CD Howe Institute report on how to improve pharmacare in Canada on the same day she made those comments.

Our report contains praise for Ontario. Ontario's system of prescription drug financing performs as well as or better than any other provincial system in Canada.

But before celebrating that point too much, the report also shows that all of Canada's provincial pharmacare models have significant flaws not found in other countries with comparable healthcare

systems.

Every other country in the world with a universal healthcare system also provides universal coverage of prescription drugs — at little or no cost to patients. In doing so, they achieve better access to necessary medicines, better financial protection for patients, and far lower total expenditures on medicines than any Canadian province does, including Ontario.

The good news for Ontario is that Minister Matthews' proposal to expand public coverage for medicines makes sense both for improved healthcare (by way of better access to needed drugs) and for Ontario's financial bottom line.

It is regarding the financial bottom line that Minister Matthews may have been given the wrong impression — perhaps by interests who oppose what is good healthcare policy concerning prescription drugs.

There is no need to delay the implementation of expanded drug coverage until the money is available. There is already more than enough money in Ontario for this.

The employers, unions, patients and tax payers of Ontario are already footing a very large bill for prescription drugs — larger than any comparable healthcare system in the world. But, because drugs are financed through a patchwork of private and public payers, Ontario is not achieving the purchasing power that comparable systems worldwide achieve.

To paint a clearer picture: if per capita spending on medicines in Ontario was the same level as it is in the United Kingdom, the people of Ontario would save nearly $6 billion every year. That is enough money to hire 16,000 more physicians, which would be a 65 percent increase in the supply of doctors in Ontario.

The government of Ontario has already shown leadership on pharmaceutical policy in recent years. It was the leader in efforts to reign in excessive prices for generic drugs in Canada. That was a tough-fought policy change that has generated hundreds of millions in savings for Ontario and elsewhere in Canada.

Ontario has also shown leadership by assisting other provinces in price negotiations with brand-name manufacturers. This not only helped smaller provinces in difficult negotiations, it also increased Ontario's negotiating power.

I hope that Ontario will continue to provide leadership by expanding prescription drug coverage in Canada.

The route forward is not to create "an open bar" for medicines in Ontario. Rather, the Ontario government should focus on providing universal coverage for medicines of proven value to the healthcare system.

The public drug program in Ontario could, for example, be expanded to provide universal access to essential drugs to treat cardiovascular disease, diabetes, asthma or mental health. If done right, Ontario would secure far more competitive prices for covered medicines, improve access to essential healthcare, and reduce unnecessary demands elsewhere in the system.

Political insiders might notice that such a policy is consistent with a proposal that Kathleen Wynne included in her Ontario Liberal Leadership platform. I'd say it's time to act. Together, Premier Wynne and Health Minister Matthews could be pioneers of the biggest, most important healthcare reform of a generation.

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A version of this commentary appeared in *Ottawa Life*, *the Windsor Star* and at CARP.ca.

New cholesterol treatment guidelines reassess statin drug use

Debate has missed the focus on patient preference

James McCormack and Mike Allan

There has been much discussion over the last few days, by journalists and health professionals, on the new guidelines for the treatment of blood cholesterol put forward by the American Heart Association (AHA) and the American College of Cardiology (ACC). Critics have raised concerns the revised guidelines will increase the number of healthy people who take statin drugs by 70 percent, that treatment thresholds are too low and that some guideline writers have links to the drug industry.

But these discussions have largely missed two key words in the new guidelines: "patient preference." The ACC/AHA state clearly, and emphatically — the term is used more than 20 times in the document — that this is a framework for clinical decision making that must incorporate "patient preferences." To put this into context, the Canadian Cardiovascular Society lipid guidelines from 2006 and 2009 make no mention of patient preferences whatsoever, and while their 2012 version contains the word "preferences" five times, only once do they actually refer to patient preferences.

This is an important transformation in guideline attitude, and here's why. No matter what recommendations this guideline or a healthcare professional may make, the patient is the one who should

decide what's best.

The biggest limitation of the ACC/AHA guidelines is that they don't provide information in a manner that easily facilitates a balanced discussion between a patient and a healthcare professional. Fortunately, it's not all that difficult.

One of the most controversial parts of the guidelines is the threshold for treatment they recommended — individuals with a 10-year heart attack and stroke risk of 7.5 percent or greater is where "risk reduction benefit clearly exceeds the potential for adverse effects." That's their opinion but what counts is your opinion.

The evidence suggests statins reduce heart attack/stroke risk by approximately 30 percent or roughly one third.

What does this mean? If you take roughly one third off of 7.5 percent (2.5 percent), the risk for heart attack and stroke would drop to around five percent. Put a different way, this means 40 people need to be treated for 10 years to benefit one person, or 97.5 percent get no clinical benefit whatsoever from statin drugs.

Let's say a higher threshold like 10 percent had been chosen instead, as some critics have argued should have been the case. Doing similar math, 10 percent goes down to seven percent (a 30 percent reduction) which is a difference of three percent. Thus, 33 people need to be treated to benefit one person and 97 percent get no benefit from taking statins. So the big debate about the threshold is a debate about a 0.5 percent 10-year difference (a three percent vs. a 2.5 percent benefit).

Now on the other end of the risk spectrum, a person with a past stroke/heart attack or an older person with many risk factors may have roughly a 30 percent risk. They would get a 10 percent absolute benefit over 10 years. This means this higher risk person (who has already had a heart attack or stroke) taking a statin for 10 years has about a one in 10 chance of benefiting from the medicine while 90 percent will get no benefit at all.

That's the benefit, so what about harm?

Muscle aches and stiffness occur in five to 10 per cent of people taking statins, with severe muscle or kidney damage occurring in roughly one in 10,000, and possible abnormal liver lab values in two percent. Some people experience nausea, constipation, diarrhea, and then, of course, there is the drug cost and the frustration of taking a pill every day. Fortunately most of these harms are reversible.

There are a few caveats. Most studies with statins have been for five years or less, so we really don't know about long-term benefit and harm. You may have also heard statins cause diabetes, but the risk increase for diabetes is only about one percent, and because statins overall reduce the risk for heart attack or stroke (the reason we treat type 2 diabetes), this risk is not clinically important.

If, after thinking about the above information, you wish to try a statin, then that is the right choice for you. If, however, you don't want to take a statin based on the information, that is also the right choice for you. In either case, you can always change your mind.

Your healthcare professional should support you no matter the decision. This is really what the new guidelines should be all about.

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and the director of evidence-based medicine in the Department of Family Practice at the University of Alberta. They both co-host a weekly podcast (Best Science Medicine Podcast) that is regularly rated one of the top medical podcasts, available through the iTunes store or at therapeuticseducation.org.

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New cholesterol guidelines mean many patients may reassess their use of statins

Alan Cassels

There was a rare ray of hope illuminating the cholesterol world this week when it was revealed that most people who are taking cholesterol-lowering (statin) drugs probably should reconsider that decision. Statins include drugs like Crestor, Lipitor or Zocor, and are currently consumed by nearly 20 percent of the Canadian adult population.

New guidelines issued by a few major heart organizations in the U.S. now say that people don't really need to be aiming for certain numerical targets by swallowing statin drugs. Perhaps the guideline writers realized that this obsession with "lower is better" around cholesterol levels isn't based on any solid evidence. Despite the fact that some researchers and physicians have been saying the same thing for years (and I've been ranting about this for at least a decade), the Good Ship Cholesterol is finally starting to alter its course.

People religiously swallowing their daily statin need reminding that cholesterol is a valuable substance in our blood and levels of so-called "high" cholesterol have always been an artifact of the pharmaceutical industry and those clinicians who believe in the "lipid theory." Even with known harms of statins (muscle-weakening, cognitive problems) the drug industry, along with cholesterol

"experts" have created a massive market worth billions of dollars by getting people (including our doctors) to worry about cholesterol targets, and driving patients to swallow drugs to achieve those targets.

This new announcement is controversial, with some cardiologists calling it a major course alteration in how doctors will treat people considered at "high risk" of cardiovascular disease. Others say that the changes lower the thresholds at which people are considered "high risk," and this will lead to even more statin overtreatment.

I can't predict the effects of the new guidelines but one thing that is very hopeful about them is that they emphasize "patient preferences." When people realize that a daily statin for five years reduces the chance of a cardiovascular event by about one percent (or five to seven percent if you have already had a heart attack), they might come to the conclusion that statins aren't worth the hassle, risk of adverse effects and the financial costs.

Knowing the miniscule effects of "high cholesterol" I think will lead people to seek out other — perhaps healthier and safer — ways to lower their cardiovascular disease risk.

The new guidelines, put out by the American Heart Association and the American College of Cardiology, are saying that targeting numerical values of what is considered "ideal" cholesterol is the wrong approach. Like with any "treat to target" approach, a number of people will never reach the targets, no matter how strong a statin they swallow, and then they are left with anxiety and feeling like a ticking time bomb just because of an arbitrary threshold that they couldn't get below.

There are a lot of things that determine your risk of future cardiovascular disease and any online Framingham calculator will help you put some numbers around what your personal risks might be. But just because something is a risk factor doesn't mean lowering it will reduce or eliminate that risk.

These new guidelines also put the kibosh on so-called cholesterol boosting drugs, such as ezetimibe (trade names: Ezetrol or Zetia) which most independent analysts have been calling a massive waste of money ever since they hit the market. This drug may lower your LDL cholesterol, but so what? Does it make a difference in your chances of having a heart attack or stroke? There's no evidence to support that. Despite this lack of any meaningful effect, it still makes its manufacturer, Merck, nearly $3 billion per year.

It's debatable whether these new guidelines will increase or decrease the use of cholesterol-lowering drugs. At the very least I think they may well help people relax, and that's a good thing. When patients start to ask their doctors about the benefits, the potential adverse effects of the drugs, and the risk of drug-to-drug interaction, a fuller and more comprehensive discussion can happen about what swallowing a daily statin will ultimately mean for them.

At the end of the day people can talk to their doctor about what they can do to reduce a future risk of heart attack or stroke, and that advice hasn't changed: a healthy diet, adequate exercise, not smoking — the usual triumvirate of healthy living advice. To that, I'll add one more: don't worry, be happy (and stop obsessing about your cholesterol numbers).

Alan Cassels is an expert adviser with EvidenceNetwork.ca, a pharmaceutical policy researcher in Victoria and the author of Seeking Sickness: Medical Screening and the Misguided Hunt for Disease*, where he writes of the folly of cholesterol screening.*

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Chapter 4: Private, For-Profit

Aligning discovery science with industry needs will stifle progress

Scientific discovery should not be hidden behind closed doors

Arya Sharma

Over the past 30 years that I have worked as a researcher in academic institutions, I have received millions of dollars in public and private funding. Yet, I hold no patent, I have not started a company and I cannot point to any commercial product that has emerged from my laboratory. The federal government, given their current push to align scientific funding with industry aims via the National Research Council (NRC), may look at this as an irresponsible waste of time and resources — I beg to differ.

The notion of focusing on "commercialization" of scientific enterprise is based on a fundamental misconception of how science works. This misconception is largely based on confusing the role and motivation of the scientist with that of the inventor.

While the scientist is primarily motivated by the desire to understand how things work, inventors are driven by the desire to make things work. While the latter lends itself to patents and commercialization, the former does not. Yet, without the former, there is nothing for the inventor to patent or commercialize.

Let me explain: The discovery of electricity and how it works is the work of scientists — harnessing this knowledge to create the light bulb (or your iPhone) is the job of inventors. Both have significant importance, but the roles are fundamentally different.

Understanding why some people get high blood pressure and how this leads to strokes and heart attacks is the work of scientists — developing an instrument to measure blood pressure or a drug to lower pressure is the work of inventors.

Not only does discovery science generally not lend itself to patents, but protecting scientific discovery with patents will in fact stifle the very commercialization it is meant to promote.

Scientific discovery, or understanding how things work, should necessarily be public information. It should not be protected by patents nor should it play out behind closed doors.

In contrast, inventions (based on ideas that emerge from scientific discovery) deserve patents and protection to ensure returns on commercialization.

Funding the scientific discovery is in the public interest because it creates the knowledge base that allows industry to invent and commercialize products that drive economic growth. In itself, however, scientific discovery does not (nor should it) be the object of patents or commercialization.

When a scientist discovers a new molecule that promotes the growth of cancer cells, it opens the field to the pharmaceutical industry to manipulate this molecule to create a new cancer drug that can be protected by patents and lead to commercial revenue for whichever company comes up with the best product to do so.

For this to happen, it is in fact essential that the discovery of the new molecule itself is not subject to a patent or protection. Rather, it is the very fact that this new discovery is now common knowledge that allows all pharmaceutical companies to compete in trying to be the first to come up with a drug that works.

Patenting or otherwise protecting the discovery of that molecule, thereby allowing its use only by a company that funded part of the research or is willing to pay for a license, in fact, eliminates competition and can only stifle progress.

Thus, for scientific discovery to stimulate commercialization and economic growth it has to be open and available to anyone who wishes to use it to create a product that creates new jobs, new revenues and opens new markets. This is why paying for scientific discovery is in the public interest and a good use of taxpayers' money, whereas paying industry to make inventions is not.

This important difference is also reflected in how scientists and inventors differ in their approach to science. Discovery scientists pursue new knowledge and compete in being the first to publish scientific papers, in the process bringing new knowledge into the public domain. Inventors work on using this new knowledge and compete to bring new products or services to market. The reward for the former is academic recognition and perhaps the Nobel Prize — the reward for the latter is a healthy bank account (only rarely do the two overlap).

While it makes good sense for governments to pay for scientific discovery, they should leave the funding and commercialization of products and services to the inventors in industry. This division of scientific enterprise has served us well in the past — it would continue to serve us in the future.

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(May 2013)

A version of this commentary appeared in *the Huffington Post*, *iPolitics.ca* and *the Waterloo Region Record.*

Dental care a gaping hole in our health system

STEPHEN HWANG

Across Ontario, going to the dentist is financially out of reach for many people. This dilemma is well-known to physicians — many of us regularly care for patients who have terrible dental problems that we are powerless to address. We see people who have delayed seeking dental care that they can't afford until they are in serious pain or their health is at risk. We see people who have trouble finding employment, miss school, or avoid social situations because of the condition of their teeth. We see people who avoid eating because their mouths constantly hurt.

Lack of access to oral healthcare is a pressing issue for a large segment of Ontario's population. Most often, this lack of access is due to economic barriers. In Toronto, a new study from the Centre for Research on Inner City Health found that low incomes are a very strong predictor of poor oral health and mouth pain. In Hamilton, a new report from the City of Hamilton's Public Health Services found that there is a clear link between poor oral health and lower income levels.

According to a report from Ontario's Chief Medical Officer of Health, 20 percent of Ontarians who stayed away from the dentist for a long time cited cost as a barrier. Nationally, cost has kept a full 16.5 percent of Canadians from seeking recommended oral healthcare.

For people who are homeless, the situation is particularly acute. Recently, researchers from the

Centre for Research on Inner City Health and the Faculty of Dentistry at the University of Toronto worked together to assess the oral health of about 200 people staying at 18 homeless shelters in Toronto. We found that 97 percent of the people we examined needed some kind of dental care and 40 percent needed emergency treatment.

Thirty-five percent of the people we surveyed had avoided eating due to mouth pain. Many had experienced pain over the last month, and most didn't seek treatment.

Dental care remains a gaping hole in our healthcare system for people with limited means. There are currently no coordinated, city-wide dental care programs for women and men experiencing homelessness in Toronto, for example. More generally, children, youth and elders are covered by a patchwork of public programs that leave many falling through the cracks.

Adults earning wages that add up to low and middle incomes have no access to public dental care programs at all. The recent discontinuation of very basic dental care for people who are refugees has made the situation even worse.

As a physician, I can tell you how much it's needed. The overall health of people living on low incomes is deeply impacted by their lack of access to dental care. The current situation in which we provide health insurance to cover the treatment of every part of a person except his or her teeth makes little sense, and leaves thousands of people to suffer from chronic pain and tooth loss.

Would we tolerate a system in which we didn't cover the treatment of eye diseases, and allowed people who didn't have the means to pay for their own care to go blind?

It's time to address the very real pain, distress and long-term health consequences caused by the fact that many in Ontario are simply not able to go to the dentist. The data on the oral health of people living in homeless shelters in Toronto simply adds to the already compelling body of evidence suggesting that oral healthcare for all should be part of Ontario's Poverty Reduction Strategy, and a permanent component of our universal healthcare system.

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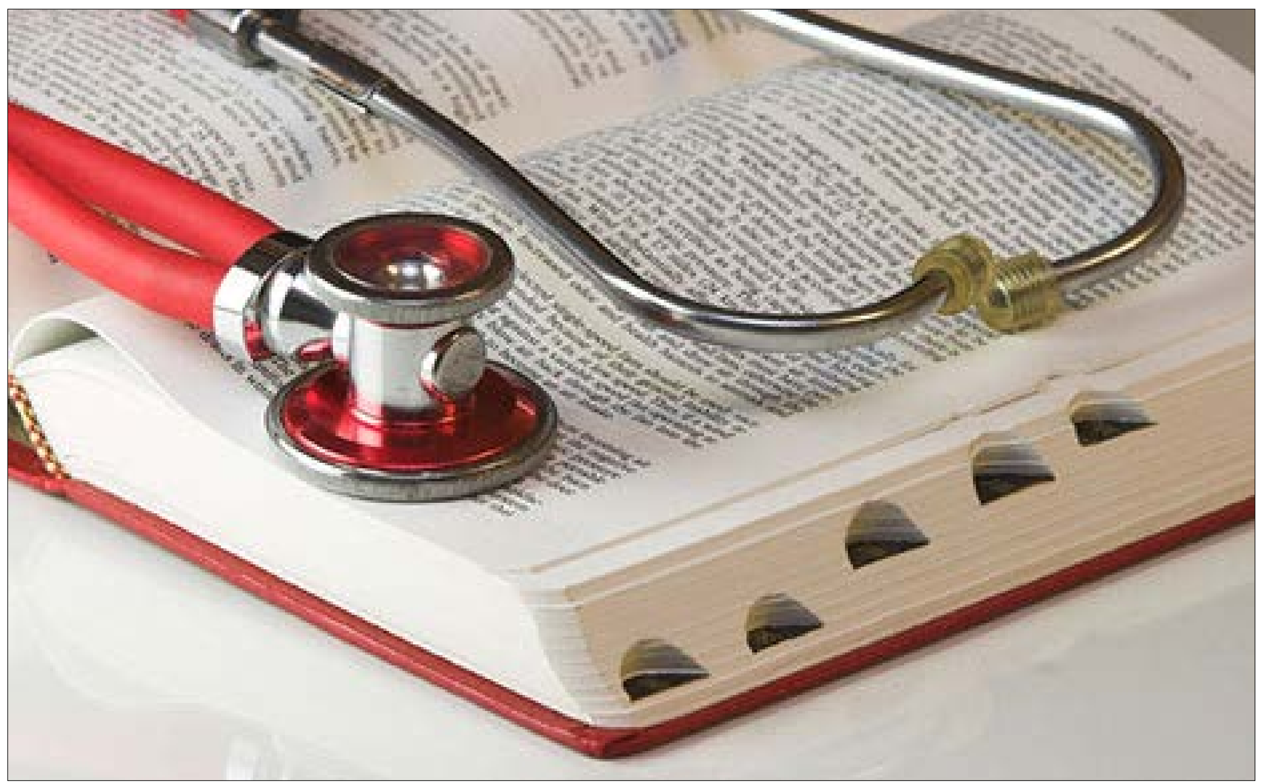
A version of this commentary appeared in *the Windsor Star*, the Vancouver *Province* and *Ottawa Life*.

Canadian medical schools have poor conflict of interest policies

Schools need regulation to prevent industry promotion during clinical training

Adrienne Shnier and Joel Lexchin



Most Canadians might be surprised to learn that medical students in Canada are routinely taught by faculty who have financial ties, and work in partnership, with drug companies. Conflict of interest (COI) policies at medical schools are important to ensure that students get an unbiased education based on the best available clinical evidence, free of industry-sponsored, commercially-driven information. After all, these students go on to become our doctors, and we want the best doctors education can provide.

So, do medical schools in Canada lack appropriate conflict of interest policies or are they simply not following them?

In a study published on July 4 in *PloS One*, we examined the COI policies at all 17 medical schools across the country. Our findings reveal a glaring problem, and something that should concern all of us. The majority of medical schools (12 of 17) have generally weak or non-existent COI policies, and four schools had policies that were moderately restrictive. Only one medical school — Western University — had stringent COI rules.

In other words, the bulk of our doctors-in-training in Canada are receiving health information that is potentially biased and misleading.

Here's a telling example: between 2002 and 2006, the University of Toronto held a pain management course for medical and other health science professional students that was partly funded by grants from Purdue Pharma LP, the maker of OxyContin. As part of the course, a chronic pain management book — funded and copyrighted by Purdue Pharma — was distributed to the students free of charge by a lecturer who worked in partnership with Purdue Pharma and was external to University of Toronto.

The wording in the book exaggerated both the benefits and the approved uses for these medications, based on the current evidence at that time. Despite recognition of these concerns by the university after a student complained, those who attended the sessions were never informed of the bias or the problematic content of the lectures and book (which was used in a related course until 2010).

The most poorly regulated areas noted in our study include curriculum selection, receiving free drug samples, visits from pharmaceutical sales representatives and taking part in speaking engagements on behalf of pharmaceutical companies.

Bottom line: Unrestrictive policies allow industry to influence medical residents' education about appropriate, effective and safe medicines, as well as prescribing choices.

Free drug samples have been found to increase the likelihood that medical residents will choose to provide medications to patients that cost more than equally effective prescription treatments, or other non-pharmaceutical options. Frequent visits by drug sales representatives are associated with influencing prescribing practices, resulting in more frequent prescribing and poorer prescribing quality.

The biggest concern, however, is the lack of education provided to medical students about the pervasiveness and effects of COI relationships with drug companies. Without such guidance, medical students, who will become prescribing physicians, graduate without being fully equipped to deal with either potential conflicts of interest in medical practice, or the influence of industry promotion on clinical judgment.

Our findings mean that industry has the ability to influence the resources provided and information that is taught to medical students. Without effective, stringent policies to regulate industry's interactions with medical students and faculty, drug companies are granted the ability to be present in medical schools and play notably influential roles in the clinical training of medical students.

If we want the best doctors in Canada, our medical schools need to revise and improve their policies to regulate conflicts of interest between medical faculty, residents and the pharmaceutical industry. These policies should address the medical curriculum and the ways in which relationships with pharmaceutical firms may affect the attitudes and information that is taught to medical students.

Medical students should be educated by medical faculty using the best available clinical evidence that is unbiased by industry so that when medical students graduate, they are able to provide their patients with the best, most effective, and safest treatments possible.

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Les politiques des écoles de médecine en matière de conflits d'intérêts sont insuffisantes

Il faut empêcher l'industrie de faire de la promotion durant la formation clinique

Adrienne Shnier et Joel Lexchin

La plupart des Canadiennes et des Canadiens seraient surpris d'apprendre que les étudiants en médecine au Canada et au Québec assistent couramment à des cours donnés par des professeurs qui ont des liens financiers et qui travaillent en partenariat avec des compagnies pharmaceutiques. Il est donc important que les facultés se dotent de politiques régissant les conflits d'intérêts pour garantir aux étudiants une formation objective, fondée sur les meilleures données cliniques disponibles, qui ne soit pas financée par l'industrie et ne donne pas de l'information de nature commerciale. Après tout, ces étudiants deviendront les médecins de demain, et nous voulons qu'ils reçoivent la meilleure formation possible.

Le problème consiste donc à savoir si les politiques existantes en matière de conflits d'intérêts sont inadéquates ou si les facultés de médecine au Canada et au Québec n'appliquent pas les politiques déjà en place.

Dans une étude publiée le 4 juillet dans *PloS One*, nous avons examiné les politiques de 17 écoles de médecine canadiennes (de langue française et anglaise) en matière de conflits d'intérêts. Nos conclusions ont révélé un problème manifeste qui devrait tous nous inquiéter. En effet, la majorité des

facultés (12 sur 17) n'ont pas de réglementation rigoureuse ou ne disposent pas du tout de politique sur les conflits d'intérêts. Dans quatre écoles, elles sont modérément restrictives, et une seule — l'Université Western — dispose de règlements stricts.

Au Québec, la réglementation en vigueur à l'Université de Sherbrooke est modérément restrictive, ce qui la classe en cinquième position, et l'Université Laval la talonne en arrivant en sixième position. Les politiques de l'Université McGill et de l'Université de Montréal sont en général timides, voire inexistantes, et elles occupent respectivement la 10e et la 14e position.

En d'autres termes, la majeure partie des médecins en formation au Canada et au Québec reçoivent de l'information sur la santé potentiellement subjective et trompeuse.

L'exemple de l'Université de Toronto est éloquent. Entre 2002 et 2006, l'Université proposait un cours sur la prise en charge de la douleur aux étudiants de médecine et d'autres disciplines des sciences de la santé. Cette formation était en partie financée par des subventions offertes par Purdue Pharma LP, le fabricant d'OxyContin. En outre, les étudiants recevaient gratuitement un manuel sur la prise en charge de la douleur dont la publication était soutenue financièrement par Purdue Pharma (qui en détient les droits d'auteur). Le chargé de cours travaillait en partenariat avec Purdue Pharma et n'était pas affilié à l'Université de Toronto.

Dans ce manuel, les avantages et les usages approuvés du médicament étaient exagérés par rapport aux données existant à l'époque. Bien que l'Université ait reconnu le problème à la suite d'une plainte d'un étudiant, elle n'en a pas informé les autres étudiants, qui n'étaient donc pas conscients du manque d'objectivité du contenu du cours et du manuel ainsi que du problème que cela représentait. D'ailleurs, ce contenu a été utilisé dans un cours connexe jusqu'en 2010.

Notre étude a noté que la réglementation faisait particulièrement défaut dans les domaines de la sélection des programmes d'études, la distribution d'échantillons médicaux gratuits, les visites de représentants pharmaceutiques et les présentations dans des conférences au nom des compagnies pharmaceutiques.

En un mot, des politiques très libérales permettent à l'industrie d'influencer les futurs médecins et leurs choix en matière de prescription, en leur fournissant de l'information sur l'efficacité et l'innocuité de leurs médicaments.

Il a été démontré que les résidents qui avaient reçu des échantillons médicaux gratuits étaient plus susceptibles de prescrire ces médicaments aux patients même si leur prix était plus élevé que celui d'autres médicaments tout aussi efficaces ou d'autres options non pharmaceutiques. Les visites fréquentes des représentants pharmaceutiques influent sur les habitudes de prescription des médecins qui ont tendance à rédiger davantage d'ordonnances pour ces médicaments, quels que soient leur efficacité ou leur coût pour le patient.

Mais l'inquiétude la plus grande vient du fait que les étudiants ne sont pas informés de l'influence des compagnies pharmaceutiques au sein de leur faculté et des conflits d'intérêts qui peuvent en découler. S'ils ne sont pas sensibilisés à ce problème, ils seront mal préparés pour faire face aux conflits d'intérêts qui pourront surgir dans leur pratique médicale ou pour déjouer l'influence de l'industrie sur leur jugement clinique.

Nos conclusions montrent que l'industrie a les moyens d'exercer une influence sur les ressources des écoles de médecine et sur l'information donnée aux étudiants. Sans politique efficace et rigoureuse pour réglementer les interactions entre l'industrie pharmaceutique, les étudiants et les professeurs,

les fabricants de médicaments s'invitent dans les facultés et jouent un rôle particulièrement influent dans la formation clinique des futurs médecins.

Si nous voulons les meilleurs médecins au Canada et au Québec, nos facultés doivent réviser et améliorer leurs politiques pour mieux réglementer les conflits d'intérêts entre toutes les parties concernées. Ces politiques doivent s'attaquer au problème des programmes d'études et à la façon dont les relations avec les compagnies pharmaceutiques influent sur l'attitude des étudiants et sur l'information qui leur est donnée.

Les cours de médecine doivent être donnés par des professeurs de la faculté attitrés. Ceux-ci doivent présenter les meilleures données cliniques disponibles en toute objectivité et sans intervention de l'industrie, pour que les jeunes médecins diplômés puissent proposer à leurs patients les traitements les plus efficaces et les plus sûrs.

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It's time to reconsider private drug plans for public employees

Michael Law

The B.C. government pays for a lot of prescription drugs.

Most people are probably aware of Fair PharmaCare, our universal public plan that covers everyone for catastrophic drug costs. This program pays for nearly $1 billion of prescription drugs every year.

Our provincial government also directly and indirectly pays for a lot of drugs through the benefit plans provided to nearly 300,000 public sector employees. In contrast to Fair PharmaCare, private companies such as Pacific Blue Cross and Sun Life administer these coverage plans.

Like Fair PharmaCare, these plans represent a large chunk of public funds: the available data suggest these plans cost just over $1,400 per employee in B.C., for a total of around $417 million every year.

These costs have not gone unnoticed. If you work in the B.C. public sector, you may have already seen a big change in your drug coverage. As part of continued moves to reduce expenditures, several major public sector unions have signed collective agreements that restrict their coverage to drugs that are covered by the provincial drug plan — a so-called "PharmaCare tie-in."

Over the next several years, it's likely that all public employees will be forced to move in this direction. This is smart public policy. It will save public funds that can be used to improve healthcare, education and other provincially run public services.

In general, the public plan chooses the most cost-effective drugs for particular treatments. So if two drugs have the same clinical effect but one is lower cost, the latter will be covered. In the past, most private drug plans for public employees paid for everything, even when cheaper and equally effective alternatives were available. The PharmaCare tie-in will reduce this wasteful spending.

It's worth pointing out that the government does all the heavy lifting for these savings: they determine the list of covered drugs, they determine the clinical criteria for their use and they process the special requests required for some drugs. The province also maintains the infrastructure to process every claim, as they already administer the Fair PharmaCare program.

All of which brings me to my key question: why are we wasting money on a private insurance middleman for public employee drug coverage?

Right now, our government is paying private insurers for what amounts to duplicative claims administration structures and processes. Why not just cover these public employees with a public plan? Such a change would be easy: public employees could simply be enrolled in a Fair PharmaCare plan that matches their existing drug plan, including the "tie-in."

This would result in major savings for two reasons. First, it would eliminate entirely wasteful duplicative administrative costs. Remember, the province is already paying for just about everything needed to administer these benefits publicly. So the current administrative cost of these private plans is almost entirely pure waste. The administrative charges for large employers in Canada are typically five percent. Once all public employees were moved over and this duplicate administration was eliminated, this would save nearly $21 million every year.

Second, private plans pay higher prices for many drugs than public plans. In recent years, the B.C. government — like other governments around the world — has negotiated discounts with drug manufacturers in return for being on the list of covered drugs. As they are confidential, we don't know how much these discounts are worth. In other countries, however, they lower overall drug costs by 20 percent or more. Private insurers in Canada have not engaged in such negotiations, so this is another area of pure savings. Even using a very conservative estimate of five percent savings, this would cut our public employee drug bill by another $21 million.

The choice essentially boils down to this: we can continue to pad the books of private insurers, or we can free up these funds for more productive uses. For example, $42 million in savings could pay for things that would benefit everyone, such as 400 additional nurses for our healthcare system, or nearly 500 new teachers in our schools.

So here's my prescription for our new Minister of Health, Terry Lake: it's time to seriously reconsider private drug plans for public employees.

Michael Law is an expert adviser with EvidenceNetwork.ca and an assistant professor at the Centre for Health Services and Policy Research (CHSPR), School of Population and Public Health at the University of British Columbia.

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Seeing clearly

Why we need routine vision testing programs for school-age children

Elizabeth Lee Ford-Jones

When I was five years old, I dropped out of kindergarten. The teacher used to get cross with me for not doing things correctly, such as passing the scissors, handles first, after a demonstration of how to do so at circle time, and I couldn't handle the stress. My mother said I did not have to go to school anymore — at least for the remainder of the year.

What wasn't discovered until a full grade later, thanks to a kindly grade one teacher who thought I was capable of more than I was doing academically, was that I had serious vision impairment — a myopia of -10 diopters, no less. In layman's terms, I was severely near-sighted.

Turns out, I wasn't being difficult when I was passing scissors incorrectly, I couldn't see them properly. Without glasses, I couldn't see much at all. No wonder school was a struggle.

Here we are, many decades later, and despite multiple recommendations from professional health organizations including the Canadian Association of Optometrists, the National Coalition for Vision Health and the Canadian Paediatric Society, there remains no standard routine vision testing or eye exam programs for school-age children and youth across the country. Some patchwork programs exist in some provinces, in some cities or for specific income groups in some communities across the

country, but many children, older kids and new Canadians are falling through the cracks.

There are kids struggling in school, just as I was, when a pair of glasses might easily solve the problem. There's only one word for this: unconscionable.

When vision impairment goes unchecked it becomes a kind of invisible disability, affecting literacy, numeracy and skill development. It can also contribute to social exclusion, as a child may hold herself back from play with peers, made difficult because of poor sight. Or, as in my own case, it can even lead to educational exclusion — when academic struggles are wrongly attributed to another cause, such as bad behaviour or cognitive ability.

According to the Canadian Association of Optometrists, one in six children has a vision problem that makes it difficult to learn and read. At present, in many regions across the country, a child's vision impairment may never be detected or is caught only as a result of attentive educators and caregivers who may suspect a problem. Only 14 percent of children in Canada under the age of six receive professional eye care.

But even when vision impairment is suspected, there remain many barriers to adequate health services, including lack of medical insurance coverage, lack of accessible transportation for appointments, the costs of taking time off work to ferry children to appointments and the out-of-pocket costs for prescription glasses or other aids. Many new immigrant families may have further struggles navigating the healthcare system due to linguistic and cultural barriers.

The good news is that there are organizations tackling this issue and making a difference, but they can't do it on their own — nor should they. For example, the non-profit Toronto Foundation for Student Success (TFSS) launched an initiative in 2007 called the Gift of Sight and Sound, with support from corporate donors and partner non-profit organizations. They screen nearly 10,000 students every year for both vision and hearing problems in the early grades in inner city Toronto.

The screening takes place directly in the school, and if potential problems are detected, children receive full exams by an optometrist. If prescription glasses are required, they are provided free of charge on-site. One in four of the students they have examined so far have had potential vision problems, and four of every five students that attended the subsequent optometry clinic received glasses.

Last year, 2,900 children in the Toronto schools received glasses; if the funding had been available for secondary school programming, the estimated numbers of glasses needed was expected to be similar.

The success of Alberta's Eye See...Eye Learn program, which tests kids before they enter grade one, is another excellent model that could be replicated across the country.

The bottom line: thousands of children in Canada are struggling needlessly, as I once did, when something as simple as a routine eye exam and corrective lenses could benefit them enormously.

The Canadian Association of Optometrists has called for a national Children's Vision Initiative to ensure that all Canadian children have a comprehensive eye exam before they enter the school system. It's time other health providers echoed this call, and our politicians heeded it.

Comprehensive eye health needs to be part of our accessible and affordable healthcare system. To do otherwise would lack real vision.

Dr. Elizabeth Lee Ford-Jones is an expert adviser with EvidenceNetwork.ca, a paediatrician specializing in social

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The above represents the opinions of Dr. Lee Ford-Jones and not necessarily the official positions of either The Hospital for Sick Children or the University of Toronto.

(August 2013)

A version of this commentary appeared in *the Toronto Star*, *the Vancouver Sun* and the *Winnipeg Free Press*.

Genetic privacy regulations may have unintended consequences

Robert L. Brown

Ontario is proposing a change to the Ontario Human Rights Code aimed at protecting people's genetic information from being used by insurance companies and employers. This would allow more people to have genetic testing done, for health or research purposes — testing they would possibly not do if they had to disclose the test results to insurers.

Supporters of the change in the Code refer to insurers as discriminating against those applying for coverage on the basis of an individual's genetic traits. And since scientists are still a long way from figuring out what the direct health implications of various genetic traits may be, the possibility for discrimination on the basis of inaccurate assumptions may indeed have a concrete basis.

The proposed privacy regulations sound like a positive move for society — a policy slam dunk. But, one can expect the insurance industry to oppose such legislation with some fairly logical and fundamental arguments. They will argue that within this possible legislation, there is a great risk of "unintended consequences." And they'll be right.

The insurance mechanism is dependent on being able to group like risks into underwriting classes and then price them according to the expected costs they bring to their pool. Today, young drivers

pay more than mature drivers for car insurance. Smokers pay more than non-smokers for life insurance. This is based on huge data pools showing connections between certain personal traits and ultimate claims (either as to timing or size of claim).

We expect more frequent or larger claims from young drivers than from mature drivers. Actuaries call this actuarial equity and the overall process "fair" discrimination (similar to prohibiting drinking until age 19). These principles have been tested many times in the courts and virtually always upheld. If and when genetic evidence creates the same irrefutable knowledge regarding health and longevity risks, insurance companies don't want to lose out on "fair" discrimination.

Another essential element of the insurance contract is that the two parties (the insurance company and the policyholder) have and share equal information. It is easy to understand that a person who knows he or she is very sick would be more apt to apply for insurance (and larger amounts thereof) than a person who knows he or she is very healthy.

For the contract to be fair, the insurer must be allowed to gather an equal understanding of the risk the applicant is going to bring to the insurance pool. Otherwise, poorer risks will cause claim payouts to be larger or to be paid earlier, thus raising the average claim cost and inevitably raising the premiums to be paid by all. Every applicant for insurance must disclose all known relevant information for the contract to be fair and for all policyholders to pay a price for their coverage that is fair for them. This is the good faith part of the contract and is essential.

Insurance companies cannot print money. All claims and expenses are paid by the premiums collected from the group of policyholders who have agreed to share the overall risk with the other members of their risk pool. If claim costs go up, so must premiums for all policyholders in the pool in the future.

Are there other alternatives?

Canada has abandoned private insurance as an alternative for paying for access to physicians and hospitals in favour of a single-payer system (federal-provincial governments via the Canadian taxpayer); the cross subsidization of healthy Canadians paying the healthcare costs of unhealthy Canadians is how the system currently operates. However, for access to drugs, homecare and such things as life insurance, most Canadians continue to rely on private insurers.

So, while changing the Human Rights Code may sound like a logical slam dunk, an unintended consequence could be the very serious erosion of one of the basic tenets of insurance which could endanger its wide availability.

Obviously, we have two schools of thought on genetic testing and its inherent privacy. Both arguments have logical foundations. We need to start a full and open dialogue around the very real issues that these arguments create. We have the time before genetic testing becomes overly popular and commonplace. Let the conversation begin.

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Chapter 5: Health is More than Healthcare

Income mobility is still a problem in Canada

Income volatility strongest for poorest 25 percent of the income ladder

Michael Wolfson

The government of Canada has remained conspicuously silent on a topic of growing concern: income inequality. While the International Monetary Fund, the OECD and the Conference Board of Canada have all expressed concern about the trends in recent years, there remain — as in the climate change debate — some deniers. Enter the Fraser Institute.

The Fraser Institute's recent study on income mobility claims it is turning conventional wisdom on its head. In a nutshell, they say income inequality in Canada is not a problem because more people have incomes that have been going up than down, particularly among the poorest earners.

This reasoning, if it were conceptually and empirically correct, would certainly provide an important caution to the Occupy Wall Street concerns about the dramatic growth in incomes of the top one percent. The Fraser Institute study does use the best data available to examine income mobility in Canada — a large Statistics Canada sample of individuals' income tax returns linked from one year to the next.

Unfortunately, its results are misleading.

The key that something is amiss is that, while the study claims to be examining relative mobility, the average proportion of individuals moving up the earnings ladder — 47 percent — is much larger than the proportion moving down the earnings ladder — 14 percent. Of course, if we look at dollars, the majority of workers have rising earnings, partly due to inflation, and partly general economic growth. But the kind of mobility the Fraser Institute purports to be examining is how one income group in 1990 is doing over time relative to another.

It is well-known that there is a broad life cycle pattern to earnings — lower entry-level wages in your early 20s, generally rising to a career maximum in your 50s, and then declining essentially to zero after age 70 when fully retired. So of course, we should expect that a great many people will see rising earnings as they move from newly minted to mid-career workers.

The Fraser study focused on younger workers in 1990, but defined its income groups based on the entire population of earners, which is generally older, and therefore has higher average earnings.

While they have not published the details of their income groups, this likely accounts for more than three times as many earners looking like they are moving up the income ladder rather than moving down.

If the analysis had been done fairly, looking at relative mobility as it claims, it would have used income groups for the specific population being studied — younger earners. Then, for every person moving up a relative position on the income ladder (e.g. from the bottom 20 percent to the top 20 percent, as in the Fraser analysis), someone else must have moved down, there being a fixed number of rungs (or 20 percent income groups in this case).

Fortunately, there is an analysis of the question of income mobility in Canada based on a more careful methodology which I co-authored a few years ago, using exactly the same income tax data base. Our results lead to quite different conclusions.

While the Fraser Institute divided earners into five broad groups, using income points bound to result in more upward than downward income mobility, we looked at much more detailed and properly relative income groups, including the bottom 10 percent up to the top one percent, and even the top 0.01 percent.

As part of our study, we assessed rationales for income inequality put forward by Milton Friedman, also cited by the Fraser Institute. One of his arguments is that high income inequality need not be ethically troublesome, because high incomes go together with more volatile incomes, and are justified, therefore, because they represent compensation for the greater risks of a volatile income.

Income mobility and income volatility are clearly linked — both relate to how much incomes move up and down over time. And if the Fraser Institute had done its analysis properly, the same number of individuals would be moving up as moving down the income ladder.

The interesting question in light of Mr. Friedman's argument is whether those with the highest incomes actually experience the highest income volatility. Our analysis showed that yes, the elite earners in the top one percent (and up) do have more volatile incomes than those at the middle and upper-middle rungs of the income ladder. But those in the bottom 25 percent of the income spectrum faced even higher income volatility.

In other words, the top one percent and even the top 0.01 percent had incomes that bounced around less than the incomes of the 25 percent at the poorest end of the income ladder. A major

reason: low earnings are often the result of "precarious" jobs which not only pay low wages, but are unstable.

Life at the top may be risky, but the real risks in life lie at the bottom of the income spectrum.

This reality of precarious jobs amongst the poor, and current research standards for unbiased analysis of income mobility, are ignored by the Fraser Institute as it tries to perpetuate the Horatio Alger "rags to riches" myth.

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Does knowing your health risks change behaviour?

Why public health campaigns may have to rethink their messaging

ARYA SHARMA

Exercise is good for you. Eat more fruits and vegetables. Stop smoking. Drink less alcohol. Such messages abound in public health campaigns and there is a firm belief that they will ultimately change behaviour. This is based on the assumption that individuals are motivated to change behaviours to reduce their individual health risks.

While healthy individuals may understandably ignore such messages, one would certainly assume that people who already have conditions amenable to behaviour change (like diabetes, heart or respiratory disease) would perhaps be more motivated to mitigate their risk by living healthier.

This, according to a study just released by Statistics Canada, is not the case. It seems that simply knowing about health risks does not change behaviour.

In fact, the 12 years of longitudinal data from the Canadian National Population Health Survey among Canadians aged 50 or older shows that three in four smokers with respiratory disease do not quit smoking, most people with diabetes or heart disease will not become more physically active and virtually no one diagnosed with cancer, heart disease, diabetes or stroke will increase their intake of fruit and vegetables.

This does not bode well for public health promotion campaigns that simply appeal to Canadians to give up unhealthy behaviours to reduce their future risk of disease.

If even those who are most likely to immediately benefit from changing their lifestyles fail to live healthier, what is to be expected of those for whom such recommendations merely promise better health somewhere in the distant future? Or, if even already having the condition does not change behaviour, why would we expect mere fear of developing the condition to be enough of a motivator?

The solution cannot be more drastic or broader messaging. One would assume that people with chronic diseases are already being provided a fair dose of health education and messaging from their health providers — certainly more than could ever be offered to the general public through broader health information campaigns.

As many experts in health promotion are well aware, knowledge and warnings are the least effective measures to change health behaviours. This is why many call for health policies that ban or restrict access to tobacco, alcohol and unhealthy foods as well as punitive measures, including taxation and fines or higher health premiums for those who persist.

However, such measures fail to acknowledge the key drivers — why people adopt unhealthy behaviours in the first place — and why these behaviours are so difficult to change.

Most people make decisions about what they eat based on taste, cost and convenience rather than on health benefits or health risks. Most people fail to exercise regularly because they either lack the time or simply do not enjoy being physically active. In certain social circles, smoking and excessive alcohol consumption are an accepted part of cultural identity — a value that supersedes potential health risks. And, let us not forget that food, nicotine and alcohol can all be used as coping strategies for a life that has its everyday stressors and challenges.

It is therefore not surprising that forward-thinking public health strategies (such as New Brunswick's "Live Well — Be Well" strategy) focus considerable effort on promoting mental fitness and resilience rather than on simplistic messages around "healthy active living."

Research shows that a higher degree of mental fitness not only increases a person's ability to efficiently respond to life's challenges but also to effectively restore a state of balance, self-determination and positive change.

Resilience is strengthened by positive relationships, experiences and inner strengths such as values, skills and commitments. It is particularly fostered by addressing our needs for relatedness (a heightened sense of belonging in the workplace, schools, communities and homes), competency (building on existing individual strengths and capacity) and autonomy (self-determination of activities that will enhance health and well-being).

Obviously, these determinants of health behaviours are far more difficult to legislate than simply banning or taxing unhealthy foods or imposing punitive levies on tobacco or alcohol. Indeed, fostering a societal discourse on the role of culture and values (including how we deal with poverty and social inequities) as a contributor to our health and well-being may well be beyond the scope of current public health initiatives. In the end, however, it will take more than warnings and by-laws to make us healthier.

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Canada can end chronic homelessness

National study puts "Housing First"

PAULA GOERING AND STEPHEN HWANG

We have the knowledge, the evidence and the strategies to improve the plight of those who fall between the cracks and stay there for long periods of time. But every night, the shelters continue to fill up, and every day, the many people who are homeless on our streets watch as we pass by with eyes averted.

At this moment, Canada has an opportunity to take action and reduce homelessness dramatically by expanding strategies we already know can work.

The federal government launched the National Homelessness Initiative in 1999, after a significant rise in homelessness. This initiative allocated more than $1 billion to funding solutions such as community programs and beds in shelters. Programs such as these play an important role, but have not measurably reduced the number of homeless people country-wide. For that reason, the current government has sought evidence on the cost-effectiveness of alternative options, such as "Housing First."

"Housing First" is based on the principle of providing housing to those in need before they're deemed "ready" to re-enter society. To qualify for housing, individuals don't need a job or a stable

lifestyle, and they don't need to enter rehab, though once they get a home, many of them will accomplish all of these things and more.

Canada will soon finish the largest randomized trial of its kind on Housing First in the world. Overseen by the Mental Health Commission of Canada with funding from Health Canada, At Home/Chez Soi has housed about 1,000 people with mental illness in five cities across Canada. Each participant was given a choice of apartments to live in, a rent subsidy and an assigned case worker for support.

The study randomly assigned 990 participants to a control group of people who only received the services already available in their cities.

About 85 percent of participants who were housed are still in the first or second apartment they chose. Not only that — many of them are thriving. Many are volunteering and enrolling in school. Many participants have accepted professional help for their mental illnesses.

Results from this study will help governments invest cost effectively in the reduction of chronic homelessness and in doing so will radically improve people's lives.

For every $2 spent on Housing First, the system saved $1 by reducing the costs of police detentions, hospital services and shelters. For those who used services the most, those savings were even greater, with $3 saved for every $2 spent.

Homelessness is more than a social issue, it's a health issue. The participants in At Home/Chez Soi all live with mental illness and they are at a much higher risk of physical illness than most Canadians. Getting appropriate healthcare is just one of the things that community support teams help participants with.

A chronic lack of affordable housing and stable employment opportunities that pay a living wage for low-skilled workers are often the reason people end up homeless in the first place. It's a game of musical chairs, and when the music stops, often those who need support the most are left standing outside the circle. But once they have a decent place to live, they can begin to reconnect with friends and rejoin the community.

The At Home/Chez Soi model is a wise investment in addressing the inequalities faced by those with complex illness.

This is ground-breaking research with the potential to help governments drastically improve Canada's approach to homelessness, social policy and our entire healthcare system. Continued support for At Home/Chez Soi and similar Housing First programs will help ensure we don't lose the crucial ground we've gained in improving the lives of Canadians.

Paula Goering at the Centre for Mental Health and Addiction and Dr. Stephen Hwang at the Centre of Research on Inner City Health, St. Michael's Hospital, are experts advisers with EvidenceNetwork.ca and investigators with the At Home/Chez Soi study. They are both researchers at the University of Toronto.

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A version of this commentary appeared in the Vancouver *Province*, *the Huffington Post* and the *Winnipeg Free Press*.

New data provides full story on income gap in Canada

Statistics Canada releases data on the top one percent income earners for first time

Michael Wolfson

Statistics Canada released data recently on the incomes of the top one percent of tax filers, and compared these to the incomes of the remaining 99 percent. Not surprisingly, this small segment of the population receives a disproportionate share of the pie — about one-tenth of all individual income, with a median income at $283,400, about 10 times the median of the bottom 99 percent.

Statscan has further provided comparable data going back to 1982, and not only by province and for the five largest cities, but also for men and women separately. Statscan has also used its CANSIM data dissemination tool (now free of charge) to provide a tremendous range of much more detailed breakdowns — enough to keep data junkies busy for days and weeks.

For example, the threshold to be in the top 0.1 percent in terms of after-tax income, at $2.2 million, is almost 14 times as high as the threshold for the top one percent. Virtually all the news coverage so far has discussed only the numbers in the Statscan text for the data release, which referred only to before-tax income.

What you may not have noticed is that this is the first time Statscan has ever produced such data as part of its standard suite of statistics. One of the challenges for a national statistical agency is to stay

relevant to the issues of the day. The Occupy movement has been news for more than a year, and we even have the elite of the business community in Davos recently putting income inequality at the top of their agenda. So these new data are most welcome.

Issues related to income inequality have been bubbling in the background amongst economists for decades. Interest amongst official statisticians recently reached a high point when former French Prime Minister Nicholas Sarkozy appointed a blue ribbon (many Nobel laureates) commission to examine serious gaps in national statistics.

The three major areas addressed by the Stiglitz/Sen/Fitoussi commission report in 2009 were the environment, well-being and incomes — including especially income inequality. The commission's reasoning on the latter was that most people cannot relate personally to GDP statistics, not least because economic growth has not been spread evenly. Middle income individuals have experienced stagnant incomes while GDP has grown over past decades. The commission's advice, therefore, was for official statistics to provide more detail on the distribution of income for individuals and families.

Statistics Canada has a long and exemplary history of producing data on incomes and income inequality. For example, in parallel with leading work by Mollie Orshansky in the U.S., Jenny Podoluk in a 1967 census monograph introduced the low-income lines that are widely used as poverty indicators. Data on the numbers of individuals and types of families with low incomes have been published annually and in detail ever since. The same household surveys used for these data are also used to provide data on those with middle and upper-middle incomes. But these surveys were never sufficiently reliable to provide data on the top one percent, so such data were not published until January 28, 2013.

Columnist Terence Corcoran wrote a blistering and unwarranted attack on Statscan for pandering to the Occupy movement by publishing data on the rich, as if these were the only income distribution data published. But if anything, the story is the opposite. Statscan is to be commended for balancing its long-standing statistical series on those with low and middle incomes with these newly available data on those with high incomes.

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Why we all discriminate — even our doctors

Learn what we can do about it

Stephen Hwang

We sometimes imagine that discrimination is a blight confined to earlier times and faraway places. Unfortunately, discrimination — that is, treating people better or worse simply because they are members of a particular socially-defined group — occurs in every aspect of our lives today, from the workplace to the doctor's office.

When researchers sent mock resumes in response to job postings in the Toronto area, a person with an English-sounding name such as "John Martin" was 40 percent more likely to be offered an interview than a person with an ethnic-sounding name such as "Arjun Kumar," even when the two resumes listed exactly the same skills and qualifications.

Discrimination can occur on the basis of socioeconomic status as well as ethnicity. In a study that we recently published in the *Canadian Medical Association Journal*, researchers called doctors' offices in Toronto while playing the role of a person looking for a family physician. Doctors' offices were 58 percent more likely to offer an appointment if the caller mentioned that he or she had a high-status job than if he or she mentioned receiving welfare.

Even within the Canadian system of universal health insurance, people with high socioeconomic

status receive preferential access to healthcare.

Why is discrimination a serious problem? Of course, discrimination is an affront to our innate sense of justice. We aspire to live in a world where people are treated fairly, and not judged by the colour of their skin or the size of their wallet.

But another reason to oppose discrimination is that it diminishes a society's overall performance and achievement. A society will ultimately be less successful if opportunities are made available to individuals on the basis of favoritism rather than merit. Numerous studies have shown that sex discrimination impedes a country's economic growth. For a healthcare system to deliver efficient and high-quality care, patients must be prioritized based on their actual need and the urgency of their condition, not their social status or personal connections.

The key to successfully reducing discrimination is to recognize that it is a universal tendency that is embedded in our human nature, rather than a failing limited to those who are "unenlightened." Discrimination does not occur only when an individual harbours overt prejudice or hatred towards a certain group of people. We are all prone to discriminate on the basis of unconscious biases that can guide our decision-making, especially when those decisions have to be made quickly, under pressure, or on the basis of limited information.

Every one of us needs to be mindful of the risk of discriminating whenever we are making decisions about people, especially those over whom we have some degree of power or influence. Even more importantly, we need to establish robust systems, policies, and procedures that reduce the potential for our biases to play a role in our decision-making. For example, when employers are hiring, they should review "blinded" resumés in which the applicants' names have been blanked out, thus forcing the employer to focus on the applicants' actual qualifications rather than their sex or ethnicity.

In the medical realm, physicians who are accepting new patients should do so on a first-come, first served basis. Prospective patients should not be subjected to a "screening visit" (sometimes known as a "patient audition") at which the physician decides whether or not to accept the individual as a patient. Any screening process creates enormous potential for discrimination, yet nine percent of the physicians' offices in our study engaged in this practice.

In Ontario, the College of Physicians and Surgeons has a formal policy that calls for physicians to accept patients on a first-come, first-served manner and explicitly states that it is inappropriate to screen potential patients. Such a policy should be strictly enforced and monitored across Canada. Physicians should welcome this action with open arms — in the interest of fairness to patients, and to set a good example for all in the fight against discrimination.

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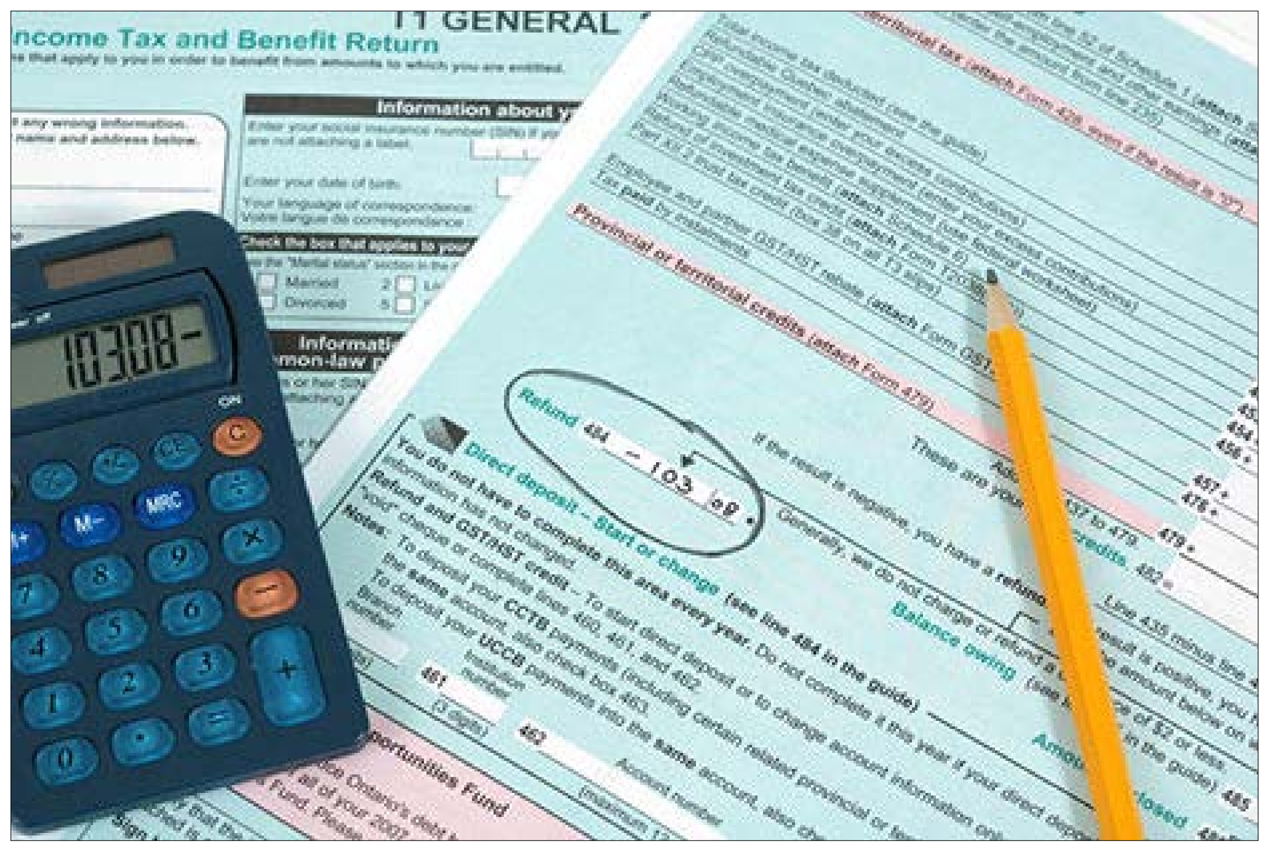
A version of this commentary appeared in *the Ottawa Citizen*, the Vancouver *Province* and *the Windsor Star*.

Why a doctor prescribes tax returns

GARY BLOCH



Tax season is upon us and my practice is humming. I am not an accountant, I am a family doctor. My patients are not bank executives, they are largely people who live in poverty, many who are homeless and on social assistance. Yet I have set out to remind my patients — each and every one of them — to fill out their tax returns.

Is this a case of confused professional identity? Have I confused RRSPs with ECGs? I don't think so. This is a powerful health intervention.

Rena, a patient of mine who suffers from high blood pressure, chronic back pain and depression, and with whom I have spent countless hours, once said to me, "Doc, if you really want to make me better, get me more money."

Rena works full time at a minimum wage job, earning just under $20,000 a year. With this, she does her best to support herself and her young daughter. However, she has not always been diligent in filing her tax returns. If she had, she could have received over $8,000 more per year in tax credits from the provincial and federal governments. That might have gone a long way to make things just a little bit better for her, including her health.

Suggesting Rena fill out her tax return is prescribing income. And prescribing income can be just as

powerful as prescribing medications for her blood pressure or her mood.

This approach is grounded in evidence.

The link between health and income is solid and consistent — almost every major health condition, including heart disease, cancer, diabetes, and mental illness, occurs more often and has worse outcomes among people who live at lower income. As people improve their income, their health improves. It follows that improving my patients' income should improve their health.

There is evidence that this approach to delivering healthcare works. Family practices in the U.K. have worked with "welfare rights advisers" for two decades. These advisers focus on helping low income patients access the income benefits they are due. These programs have been shown to improve patients' income and sense of well-being in the short-term studies that have been conducted so far.

Closer to home, a study conducted in Dauphin, Manitoba in the 1970s, recently analyzed by health economist Evelyn Forget, showed that an income supplement offered to an entire town reduced hospital visits, birth rates, and hospitalizations for mental illness, accidents and injuries.

It is true that the most meaningful answer to addressing poverty lies in much larger scale interventions than my attempts to have my patients fill out their tax returns. In fact, the same can be said for many conditions we treat. We can combat heart disease with cholesterol and blood pressure medication, but what about reducing saturated fats in processed foods? Diabetes can be improved with metformin and insulin, but what about decreasing access to sugary drinks?

We do our best to treat each patient and their illness in our own practices while advocating for broader policy change. The same approach is necessary for fighting poverty. As doctors we need to, and we can, prescribe income while advocating for real, effective policies to combat poverty.

I will continue to advise my patients to exercise more and eat healthier food, but this tax season I will also spend time prescribing tax returns. Income is a powerful determinant of health — more so than many medications I prescribe. I will do my part to make it a positive force in the health of my patients.

Dr. Gary Bloch is a family physician with St. Michael's Hospital in Toronto, and the chair of the Ontario College of Family Physicians' Committee on Poverty and Health. He is an expert adviser with EvidenceNetwork.ca.

A patient guide to improving income can be found at: http://www.healthprovidersagainstpoverty.ca/system/files/Patients_Income_Brochure.pdf

A guide to free income tax clinics for people living on low incomes can be found at: http://www.cra-arc.gc.ca/tx/ndvdls/vlntr/clncs/on-eng.html

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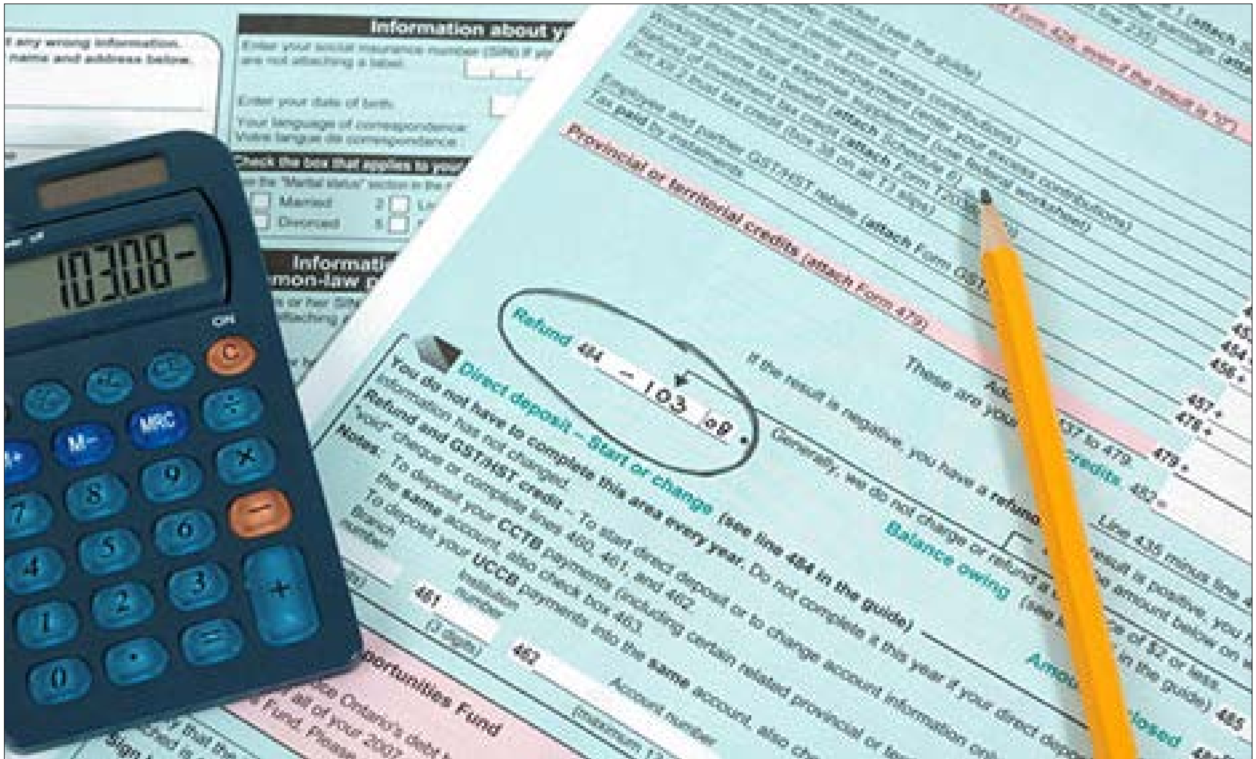
A version of this commentary appeared in *the Globe and Mail, the Huffington Post* and *the Winnipeg Free Press.*

Un médecin prescrit des déclarations de revenus

Gary Bloch



La période des impôts est de retour et mon cabinet fonctionne à plein régime. Je ne suis pas comptable, mais plutôt médecin de famille. Mes patients n'occupent pas les fonctions de cadre supérieur dans une banque, ils vivent en grande partie dans la pauvreté. Plusieurs sont sans-abri ou assistés sociaux. Pourtant, je me fais un devoir de rappeler à tous mes patients, sans exception, de produire leur déclaration de revenus.

S'agit-il d'un cas de confusion d'identité professionnelle? Est-ce que je mélange REER et ECG? Je ne crois pas. Il est question ici d'une puissante intervention en santé.

Rena, l'une de mes patientes, qui souffre d'hypertension, d'un mal de dos chronique et de dépression et avec qui j'ai passé un nombre incalculable d'heures, m'a dit un jour : « Docteur, si voulez vraiment que j'aille mieux, trouvez-moi de l'argent ».

Rena travaille à temps plein au salaire minimum et gagne un peu moins de 20 000 $ par année. Avec ce revenu, elle fait de son mieux pour subvenir à ses besoins et à ceux de sa petite fille. Toutefois, elle n'a pas toujours produit assidûment ses déclarations de revenus. Si elle l'avait fait, elle aurait reçu des crédits d'impôt provinciaux et fédéraux de plus de 8 000 $ par année. Ceux-ci auraient pu contribuer grandement à améliorer un petit peu sa situation, notamment sa santé.

Le fait de suggérer à Rena de produire sa déclaration de revenus équivaut à lui prescrire un revenu. Et pour sa pression sanguine ou son humeur, une prescription de revenu peut s'avérer aussi puis-

sante qu'une ordonnance de médicaments.

Cette approche se fonde sur des données probantes.

Le lien entre la santé et le revenu est solide et constant — presque tous les problèmes de santé sérieux, y compris les maladies du cœur, le cancer, le diabète et les maladies mentales, se manifestent plus souvent et ont les pires conséquences chez les personnes qui gagnent les plus faibles revenus. À mesure que les gens améliorent leur revenu, leur santé prend du mieux. Par conséquent, si le revenu de mes patients progresse, il devrait en être de même pour leur état de santé.

Les études démontrent que cette approche en matière de prestation de soins de santé fonctionne. Au Royaume-Uni, les omnipraticiens collaborent avec des « conseillers en droits de l'aide sociale » depuis deux décennies. Ces conseillers s'occupent d'aider les patients à faible revenu à avoir accès aux prestations de revenu auxquelles ils ont droit. Dans les études à court terme qui ont été entreprises jusqu'à maintenant, il a été démontré que ces programmes amélioraient le revenu des patients et leur sentiment de bien-être.

Plus près de chez nous, une étude menée à Dauphin, au Manitoba dans les années 1970, qu'a récemment analysée l'économiste du secteur de la santé Evelyn Forget, indiquait qu'un supplément du revenu offert à toute une ville avait permis de réduire les visites à l'hôpital, le taux de natalité et les hospitalisations pour maladie mentale, les accidents et les blessures.

Il est vrai que la réponse la plus efficace pour contrer la pauvreté réside dans des interventions à une échelle beaucoup plus grande que mes tentatives auprès de mes patients pour les inciter à produire leur déclaration de revenus. En fait, cela s'applique également à plusieurs affections que nous soignons. Nous pouvons lutter contre les maladies du cœur avec des médicaments pour réguler le cholestérol et la pression sanguine, mais qu'en est-il de la réduction des gras saturés dans les aliments transformés? La metformine et l'insuline permettent d'améliorer le contrôle du diabète, mais que dire de restreindre l'accès aux boissons sucrées?

Nous faisons de notre mieux pour traiter chaque patient et sa maladie dans notre pratique tout en plaidant en faveur de changements politiques beaucoup plus vastes. La même approche s'impose pour contrer la pauvreté. En tant que médecins, nous devons, et nous pouvons, prescrire un revenu tout en prônant des politiques vraiment efficaces pour lutter contre la pauvreté.

Je continuerai de recommander à mes patients de faire plus d'exercice et de manger plus sainement, mais en cette période des impôts, je passerai également du temps à prescrire des déclarations de revenus. Le revenu constitue un puissant facteur déterminant de la santé, plus encore que les médicaments que je prescris. Je ferai tout mon possible pour qu'il ait un effet positif sur la santé de mes patients.

Dr. Gary Bloch exerce comme médecin de famille à l'Hôpital St. Michael de Toronto en plus de présider le Comité sur la pauvreté et la santé du Collège des médecins de famille de l'Ontario. Il agit également à titre d'expert-conseil à EvidenceNetwork.ca.

Un guide sur les comptoirs de préparation des déclarations de revenus par des bénévoles pour les personnes à faible revenu se trouve à : http://www.cra-arc.gc.ca/tx/ndvdls/vlntr/clncs/on-fra.html

Un guide du patient sur l'amélioration du revenu se trouve à : http://www.healthprovidersagainstpoverty.ca/system/files/Patients_Income_Brochure.pdf

(mars 2013)

Une version de ce commentaire est parue dans *le Huffington Post Québec* et *le Soleil*.

Time to tackle the rooming-house paradox

More than 50,000 Canadians are among the "hidden homeless" each day

JINO DISTASIO

On any given night, thousands of Canadians languish in ramshackle housing, line up at shelters or sleep in our streets and alleyways. This situation is not limited to our big cities, with the Homeless Hub estimating that on any given day, 30,000 Canadians are without homes.

How can it be that in such a prosperous country we continue to struggle to house those most in need?

How, too, can we have a contest in Winnipeg that asks folks to name and photograph the worst place to live? Not surprisingly, "the winners," which were drawn from no shortage of entries, were rooming houses located in the inner city. Sadly, this same contest could be replicated across the country with similar "winners" easily identified in every major Canadian city.

Is there a simple solution to such poor quality housing? Perhaps we could start by shutting down as many of these godforsaken places as we can. But, as others have pointed out, closing rooming houses and other marginal forms of shelter — even the poorest quality ones — might cause more harm than good. Here's why.

For more than a decade, the University of Winnipeg's Institute of Urban Studies undertook several projects exploring rooming houses and single-room-occupancy hotels (SROs). What we found was an industry rife with contradiction, comprised of Samaritans and villains willing to help or exploit. In an initial estimate, we contended that there are as many as 10,000 people comprising the "hidden homeless" population of Winnipeg alone. As well, the Homeless Hub conservatively estimates that there are 50,000 Canadians who are part of the "hidden homeless" population on any given night.

Many of these "hidden homeless" live in rooming houses, SROs or "sofa-surf" from temporary place to place.

How did we get here?

In Canada, we allowed our affordable housing stock to spiral downward in two fundamental ways. First, the federal government significantly diminished its role in the provision of and funding for affordable housing, off-loading the responsibility to the provinces, which have not been able to build enough units.

Second, most provinces across the country allowed what remained of affordable housing to decline, leaving many to scramble for the worst of the worst, including rooming houses and SROs.

To tackle the problem of poor-quality housing, a practical solution would be for provinces to better enforce building codes, occupancy standards and the licensing of rooming houses and SROs, with the mandate to close the worst offenders.

This swift action would effectively shut many down. However, in doing so we would have to realize that for a heavy handed approach, a hefty price would be paid, as many of our "hidden homeless" would be plunged into crisis, ending up on the streets and putting increased pressure on our already burdened shelters.

Herein lies the paradox. While we know it is critical to have all Canadians living in safe, affordable housing, closing thousands of rooms would put massive pressure on an already strained system. Yet, perhaps this course of action is exactly what is needed, since the excuse of having no alternatives is simply not good enough any longer.

Perhaps such action would not only provoke a strong tri-level government reaction — but they would be forced to find alternatives, including not only building new affordable housing units but also offering the right supports to keep people housed.

In work by the At Home/Chez Soi project over four years, we learned much about keeping people securely housed. The solution was never about simply providing housing; it was also about creating a strong network of individualized supports that included mental health, addictions, employment and quality of life. This ensured the right resources were made available to keep people stably housed. The Housing First approach used in the project provides strong evidence that supports along with housing go a long way to changing lives — and saving the system money in the long run.

As we move forward, we have to realize that we need to invest in all of our citizens. We have to work hard to make available the right types of resources and services to help those in need find their own pathway to success. But success must include a safe and secure home.

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Canada's doctors call for action on healthy equity

Doctors link income, education, housing and nutrition to health inequities

RYAN MEILI

The Canadian Medical Association (CMA) held its annual General Council in Calgary from Aug. 18 to 21. Last summer in Yellowknife, I attended this meeting as a representative of Canadian Doctors for Medicare. It was not at all what I'd expected.

The CMA, as a professional association representing doctors, has often been seen — fairly or unfairly — as working primarily for the interests of physicians, with patients and health equity appearing at times to be an afterthought. This impression was particularly prevalent during the presidencies of Brian Day (2007–8) and Robert Ouellet, (2008–9), both vocal advocates for privatization (and owners of private, for-profit healthcare facilities) who used their tenure to advocate for greater private payment for essential health services.

As someone who had come to view the organization with some degree of distrust, the Yellowknife meeting was like stepping into a "bizarro" CMA. The keynote speaker was Sir Michael Marmot, who brought the challenging message that "inequality is killing on a grand scale" and that governments and physicians, must address the causes of health inequities.

We've known for decades that healthcare is only one element in determining health outcomes; a far

less influential factor than income, education, housing, nutrition and the wider environment. However, this information has had little impact on how medicine is practiced, and this can be frustrating for doctors, uncertain of how to translate this from the conceptual to the clinical.

A paper released by the CMA at that Yellowknife meeting on the role of the physician in achieving health equity encouraged doctors to think differently about how they can address the social determinants of health in practice.

This theme has been getting increasing attention through the CMA presidencies of Jeff Turnbull in Ontario, John Haggie in Newfoundland, Yellowknife's Anna Reid, (and now Edmonton's Louis Francescutti), and was taken a step further with the recent release of "Healthcare in Canada: What Makes Us Sick." The result of a series of town halls across Canada, this report underlines the degree to which four key determinants — income, housing, nutrition and food security, and early childhood development — influence the health and well-being of Canadians.

It also goes a step further, proposing a dozen recommendations on how to address these determinants. They include important general ideas such as strategies to address poverty, housing, food security and the health of Aboriginal people. They also propose more specific changes like Pharmacare, Housing First initiatives and guaranteed annual income: ideas that could be considered quite radical in today's political context.

Yet here they are, coming from what is thought to be one of the most conservative professional organizations in the country. Why? Because whatever self-interest may influence physician politics, the purpose of the profession is still, at its heart, to work toward the best health outcomes for patients.

The weight of the evidence for the social determinants of health, and the need for creative, system-wide policy changes to address them, is simply too great to ignore.

In Yellowknife, Sir Michael Marmot was kind enough to offer a few words of introduction at the local launch of my own book that deals with the social determinants of health, *A Healthy Society*. I was honoured that he had read the book. He did, however, take umbrage with one section of the book, in which I quoted Dr. Dennis Raphael who has described the social determinants of health as a concept existing in a "Phantom Zone," well-known to academics but failing to make the leap into the consciousness of decision-makers or the general public. Marmot said that disconnect no longer applies, and cited the CMA meeting as an example that these concepts are becoming mainstream and could influence policy.

I hope he's right, and I think this paper from the CMA is a remarkable piece of evidence that the tide of public and professional opinion is turning in this direction.

There is still, however, growing inequality in Canada, there are still housing and homelessness crises in many Canadian cities, food insecurity — especially among First Nations and Métis people — is a chronic problem, and early childhood development programs are inconsistent and inadequate across the country.

In other words, there is still a lot of work to be done to make sure that recognition of the role of social factors in determining health outcomes translates into action that improves the lives of Canadians. Listening to the voice of Canadian doctors and following the recommendations outlined in "What Makes Us Sick?" would be a healthy start.

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Les médecins face à ce que nous rends vraiment malade

RYAN MEILI

Au mois d'août s'est tenue à Calgary l'assemblée annuelle de l'Association médicale canadienne (AMC). J'avais assisté déjà, l'année dernière, à celle de Yellowknife à titre de représentant de Médecins canadiens pour le régime public (Canadian Doctors for Medicare). J'avais été agréablement surpris, car cela ne s'était pas du tout passé comme je m'y attendais.

L'AMC étant une association professionnelle de médecins, elle a souvent été perçue — à tort ou à raison — comme défendant avant tout les intérêts des médecins, les patients et la santé en général ne servant souvent que de faire valoir après coup. Cette perception était particulièrement répandue sous les présidences de Brian Day (2007–2008) et Robert Ouellet, (2008–2009). Ces derniers — eux-mêmes propriétaires de cliniques privées — s'étaient faits les avocats d'une plus grande privatisation des soins de santé.

J'étais donc plutôt méfiant à l'égard de l'Association et je n'aurais pas imaginé assister à une telle réunion à Yellowknife. Or, le message du principal conférencier invité, Michael Marmot, était que «l'inégalité tue à grande échelle » et que les gouvernements et les médecins doivent avant tout s'attaquer aux causes de ces inégalités en santé.

Nous le savons en effet depuis longtemps, les soins en eux-mêmes ne sont qu'un élément parmi les

nombreux facteurs qui déterminent la bonne santé d'un individu. Un élément moins important cependant que le revenu, l'éducation, le logement, la nutrition et l'environnement. Mais cette connaissance a eu peu d'impact sur la façon dont on a pratiqué la médecine jusqu'à présent. Et c'est encore très frustrant pour les jeunes médecins, qui sont souvent incapables de traduire cette approche dans leur travail quotidien sur le terrain.

Un document publié par l'AMC lors de cette réunion à Yellowknife encourageait d'ailleurs les médecins à penser différemment afin d'intégrer justement les facteurs sociaux dans leur pratique.

Cette approche a fait l'objet d'un intérêt grandissant à l'AMC sous les présidences de Jeff Turnbull, de John Haggie, d'Anna Reid et maintenant de Louis Francescutti. Elle a même franchi une nouvelle étape avec la sortie récente de « Les soins de santé au Canada : Qu'est-ce qui nous rend malades? » Ce rapport est le compte rendu d'une série d'assemblées publiques tenues partout au Canada. Il souligne l'importance des quatre facteurs influençant le plus la santé et le bien-être des Canadiens : le revenu, le logement, l'alimentation et le développement de la petite enfance.

Le rapport va même encore plus loin, proposant une douzaine de recommandations sur la façon d'aborder ces facteurs déterminants. Comment, par exemple, combattre la pauvreté, s'attaquer au manque de logement, favoriser la sécurité alimentaire et la santé des Autochtones. Il propose également des changements plus précis, comme l'assurance-médicaments, la « Priorité au logement » ou le revenu minimum annuel garanti. Des changements pouvant être considérés comme assez radicaux dans le contexte politique actuel.

Notons que ces propos viennent de l'une des organisations professionnelles les plus conservatrices du pays. Il faut croire qu'en dépit des intérêts corporatifs et personnels, l'objectif des médecins reste toujours la santé de leurs patients. L'impact des facteurs sociaux sur la santé des individus et la nécessité d'y faire face politiquement ne peuvent tout simplement pas être ignorés.

À Yellowknife, M. Michael Marmot a eu la gentillesse de dire quelques mots au lancement de mon livre qui traite précisément des facteurs sociaux en santé, A Healthy Society (Purich Publishing, 2012). J'étais bien sûr flatté qu'il ait lu mon livre même s'il a critiqué un passage dans lequel je cite le Dr. Dennis Raphael pour qui ce concept de facteurs sociaux est relégué dans « une zone fantôme », bien connu des universitaires et des chercheurs, mais encore totalement absent de la conscience des décideurs et du grand public. Marmot m'a un peu corrigé en disant que ce n'était plus vrai, les discussions au congrès de l'AMC en étaient la preuve. Selon lui, cette approche est de plus en plus reconnue et, dans un avenir plus rapproché que l'on pense, elle influencera les politiques de la santé.

J'espère qu'il a raison. Je pense par ailleurs que ce document de l'AMC est une indication certaine que l'opinion du public et des professionnels s'en va dans la bonne direction.

En attendant, les inégalités s'accroissent de plus en plus chez nous, le manque de logement et l'itinérance affectent encore de nombreuses villes canadiennes, l'insécurité alimentaire — en particulier chez les Premières Nations et les Métis — est un problème chronique, les programmes de développement de la petite enfance sont obsolètes ou inadéquats…

En d'autres termes il reste encore beaucoup de travail à accomplir pour faire admettre à tous, professionnels de la santé et opinion publique, que les facteurs sociaux jouent un rôle essentiel dans la santé de la population. Mettre en application les recommandations proposées dans « Qu'est-ce qui nous rend malades? » serait certainement un bon départ.

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Poverty linked to multiple health problems in new mothers, study

Why social policy is health policy

Patricia O'Campo

As health equity researchers, it's part of our job to measure the relationship between social conditions and health outcomes. Often, we try and link one social condition, like income, to one health outcome, like diabetes, low birth weight or mental illness — the list goes on. Using this approach, we are able to demonstrate when low income is associated with a higher risk of having a specific problem. What we don't generally measure, however, is the overall impact of low income on physical and mental health.

So what happens when we try? At the Centre for Research on Inner City Health, we analyzed health survey data representative of more than 75,000 Canadian women who had recently given birth. We looked at the relationship between low income and the risk of experiencing three to five of these health conditions at the same time: adverse birth outcomes, postpartum depression, serious abuse, hospitalization during pregnancy and frequent stressful life events.

The results were staggering. We found that new mothers living on very low incomes were more than 20 times more likely to experience multiple health problems than new mothers living on high in-

comes. Compare this to the "single disease" method through which we often find that people living on low incomes are only twice as likely — if that — to experience a specific health problem.

Our evidence also suggests that if we were able to ensure all new mothers in Canada had household incomes of more than $50,000 a year, we could reduce the occurrence of multiple health problems in pregnancy by 60 percent.

These findings tell us that low income doesn't just lead to one disease or another. Instead, it has wide-ranging impacts on the health of individuals and communities. These findings also tell us that, as researchers, we've been using the wrong tools, and typically underestimating the full impact of income on health.

So now that we have a more accurate assessment of the impact of low income on well-being, what kind of solutions do these findings suggest? To some degree, the healthcare system is already recognizing that some populations face multiple health problems. Recent responses have included a much-needed emphasis on case coordination and collaboration between different parts of the system like primary care, hospitals, home care and long-term care. These are good things. Program responses like diabetes education centres and stress reduction classes can be good things too.

The healthcare system, however, is not the only place — or even necessarily the most important place — to focus our efforts to improve the health of the population.

Instead, our evidence suggests the incredible potential of focusing our attention on low income itself. If we want to know how to improve the health of Canadians on a large scale, programs and health system changes — while very important — are not the answer. The answer is to institute policies that address the social determinants of health, such as education, housing and employment, and change the conditions themselves.

What does this look like in practice? We can start by acknowledging that our health is largely determined by factors that sit outside of the healthcare system. This is a fact that many people are aware of, but now we have data and some startling numbers to back it up. As a result, we can see that, in a very real sense, social policy is health policy.

As a long-term goal, we should work to foster collaborations between sectors like housing, health and employment, and between levels of government, to coordinate services and measure health impacts. In the short-term, we must invest in policies that address income. There are many opportunities, from bringing income assistance programs, unemployment benefits and minimum wage in line with the real cost of living, to boosting provincial child benefits to the level needed to make sure all children across the country lead healthy lives.

The evidence shows us that the health of mothers, babies and families are at stake, and there's no more time to lose.

To read more about this study, please visit: http://www.crich.ca/outreach/crich-research-flash

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Étude sur les liens entre pauvreté et problèmes de santé multiples chez les nouvelles mères

Pourquoi la politique sociale est une politique de santé

Patricia O'Campo

En tant que chercheurs sur l'équité en santé, notre travail nous amène notamment à mesurer les liens entre les facteurs sociaux et l'état de santé. Souvent, nous essayons de relier un facteur social comme le revenu, à un état de santé comme le diabète, l'insuffisance de poids à la naissance ou la maladie mentale — la liste est longue. Une telle approche nous permet de montrer dans quels cas un faible revenu est associé à un risque accru de développer un problème particulier. Toutefois, ce qu'en général nous ne mesurons pas, c'est l'incidence globale d'un faible revenu sur la santé physique et mentale.

Alors, que ce passe-t-il lorsque nous essayons de le mesurer? Au Centre for Research on Inner City Health, nous avons analysé des données d'enquête sanitaire représentatives de plus de 75 000 femmes canadiennes ayant accouché récemment. Nous avons examiné le lien entre un faible revenu et le risque de développer simultanément de trois à cinq des troubles de santé suivants : issues défavorables de la grossesse, dépression postpartum, sévices graves, hospitalisation durant la grossesse et fréquents événements de la vie stressants.

Les résultats ont été stupéfiants. Nous sommes arrivés à la conclusion que les nouvelles mères vivant avec de très faibles revenus étaient plus de 20 fois plus susceptibles d'avoir des problèmes de santé multiples que les nouvelles mères ayant des revenus élevés. Comparez ce résultat avec celui de la méthode axée sur une seule maladie, laquelle nous amène souvent à conclure que les personnes vivant avec de faibles revenus ne sont que deux fois plus susceptibles — tout au plus — de développer un problème de santé particulier.

Le Québec s'enorgueillit d'avoir l'un des taux de pauvreté les plus bas parmi les provinces et territoires du Canada. Pourtant, dans l'échantillon étudié, encore près de 20 pour cent des mères ayant accouché au Québec avaient éprouvé des difficultés financières pour répondre aux besoins essentiels de leur famille.

Nos données probantes donnent également à penser que si nous étions en mesure d'assurer à toutes les nouvelles mères du Canada des revenus de ménage supérieurs à 50 000 $ par an, nous pourrions réduire de 60 pour cent l'occurrence des problèmes de santé multiples durant la grossesse.

Ces résultats nous indiquent qu'un faible revenu ne fait pas que mener à une maladie ou une autre. Il a plutôt des répercussions étendues sur la santé des personnes et des collectivités. Ces résultats nous indiquent également que, nous chercheurs, nous avons utilisé les mauvais outils et généralement sous-estimé les conséquences globales du revenu sur la santé.

À présent que nous évaluons de manière plus exacte les répercussions d'un faible revenu sur le bien-être, quel genre de solutions ces résultats suggèrent-ils? Dans une certaine mesure, le système de soins de santé reconnaît déjà que certaines populations sont confrontées à des problèmes de santé multiples. Les mesures prises récemment incluaient une insistance particulièrement bienvenue sur la coordination des cas et la collaboration entre les différentes parties du système, comme les soins primaires, les hôpitaux, les soins à domicile et à long terme. Ce sont de bonnes choses. Les mesures prises dans certains programmes comme les centres d'éducation sur le diabète et les cours de réduction du stress peuvent également être efficaces.

Le système de santé n'est cependant pas le seul élément — ni même nécessairement l'élément le plus important — sur lequel axer nos efforts pour améliorer la santé de la population.

Nos données probantes évoquent plutôt l'incroyable potentiel lié au fait de concentrer notre attention sur le faible revenu lui-même. Si nous nous demandons comment améliorer la santé de la population canadienne à grande échelle, les modifications des programmes et du système de santé — bien que très importants — ne sont pas la réponse. La réponse est d'instituer des politiques s'attaquant aux déterminants sociaux de la santé, tels que l'éducation, le logement et l'emploi, et de changer les conditions elles-mêmes.

Concrètement, de quoi s'agit-il? Nous pouvons commencer par reconnaître que notre santé est en grande partie déterminée par des facteurs extérieurs au système de soins de santé. C'est un fait connu de nombreuses personnes, mais à présent nous disposons de données et de quelques chiffres effarants pour l'étayer. Par conséquent, nous pouvons voir que la politique sociale est véritablement une politique de santé.

À long terme, nous devons travailler en vue de favoriser les collaborations entre des secteurs comme le logement, la santé et l'emploi, et entre les paliers de gouvernement, afin de coordonner les services et mesurer leurs répercussions sur la santé. À court terme, nous devons investir dans des politiques de soutien du revenu. Les possibilités sont nombreuses — de l'ajustement des programmes

d'aide financière, des prestations de chômage et du salaire minimum au coût de la vie réel, à l'augmentation des prestations provinciales pour enfants au niveau requis afin de s'assurer que tous les enfants du pays vivent en bonne santé.

Les données probantes nous montrent que la santé des mères, des bébés et des familles sont en jeu et qu'il n'y a plus de temps à perdre.

Informez-vous sur cette étude en consultant le site www.crich.ca/outreach/crich-research-flash

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Postpartum depression is a family affair

It can affect dads and other children too

NICOLE LETOURNEAU AND JUSTIN JOSCHKO

At long last, people are talking about postpartum depression. Dismissed for years as no more than a touch of the baby blues or else unheard of entirely, postpartum depression — or PPD, as it is often known — has become an open subject. Healthcare providers are aware of it, many nurses and physicians routinely screen mothers for it, and articles in parenting magazines and major newspapers have been written about it.

But despite this progress, postpartum depression remains misunderstood in one very critical regard: namely, that it's something that only happens to, and thus only adversely affects, mothers.

This assumption causes problems for two reasons. First, it ignores the fact that both men and women can suffer from PPD. Though more common in mothers — affecting anywhere from 10 percent to 25 percent of them — PPD also affects 10 percent to 14 percent of new dads. The symptoms for paternal and maternal PPD overlap considerably, including fatigue, irritability, and withdrawal, and they occur at the same point in time — roughly a month after the baby is born.

What's more, the two groups appear closely connected. Among fathers suffering from PPD, a full half of them have partners who are suffering themselves. This means that in a significant number of

households affected by PPD, both adults are suffering together.

This leads to the second problem: PPD's effect on children.

During the first two to three years of their lives, children grow millions of neural connections a second — far more than they will ever need — in order to allow their brains to develop in whatever way best suits their environment. This adaptability, called neural plasticity, decreases with age, as the most used connections thicken and strengthen and the neglected ones wither and shrink.

This brief window of phenomenal adaptability allows children to learn complex procedures, such as motor skills and language, at an incredible rate.

Unfortunately, it also makes them vulnerable to the anxiety, frustration and emotional strain caused by depression. These problems sink into their malleable minds like fingers into putty, leaving marks that may never fully disappear. Consequently, children of depressed parents have a heightened risk of many emotional, intellectual and behavioural problems — especially when both parents are suffering.

Sometimes these symptoms take years to show up — a recent study found that having a depressed mother at age two predicted a greater risk of anxiety at age 11 — but when the symptoms do show up, they often stick around. PPD has been linked to anger issues and withdrawal in infancy, aggression, anxiety and lower IQ scores in school-age children, and drug use, alcoholism and ADHD in teenagers.

These conditions often impact children's chances of long-term success, and can lead to lower levels of education, increased risks of poverty and a host of mental and physical disorders.

Given such long-standing consequences, it's all the more vital that we develop a proactive support system for mothers and fathers afflicted with PPD. Comprehensive postnatal screening would allow training clinicians to spot individuals who may be suffering, and a network of professional counsellors and peer groups would help new parents manage the symptoms of PPD before they get out of hand — and also help them feel less alone.

The benefits of such a program extend far beyond just helping parents. A solid prenatal and postnatal support system — not just for those with PPD, but all parents struggling with poverty, addiction, or psychological problems — would give otherwise at-risk children a chance to thrive.

Parents don't just raise children; they raise the next generation of workers, innovators and leaders. By helping them, we help their children, our society and ourselves.

PPD is not the only problem requiring a family first solution — but it is a good place to start. Support for parents who are struggling is a down payment on a brighter future.

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Justin Joschko is a freelance writer currently residing in Ottawa. Their co-authored book, Scientific Parenting, *has just been released with Dundurn Press.*

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La dépression postpartum est une affaire de famille

NICOLE LETOURNEAU ET JUSTIN JOSCHKO

La dépression postpartum. Enfin, les gens en parlent. Pendant des années, on lui accordait peu d'importance et on la considérait comme un simple vague à l'âme après l'accouchement. Dans certains milieux, elle était inconnue. La dépression postpartum, ou la DPP comme elle est souvent appelée, est devenue un sujet ouvert. Les professionnels connaissent le problème, nombre d'infirmières et de médecins font du dépistage systématique auprès des mères et des articles sur cette question ont été publiés dans des revues pour parents et les grands journaux.

Or, malgré ces progrès, l'incompréhension demeure, notamment concernant un point important. Selon la croyance, seules les mères en sont touchées et en subissent les effets.

Ce postulat est erroné, et ce pour deux raisons. D'abord, il ne tient pas compte du fait que tant les hommes que les femmes peuvent souffrir de DPP. Bien qu'elle soit plus fréquente chez les mères, touchant de 10 à 25 pour cent d'entre elles, la DPP frappe aussi 10 à 14 pour cent des pères. Les symptômes de la DPP paternelle et maternelle se recoupent considérablement et comprennent la fatigue, l'irritabilité, le repli sur soi-même. Ils se manifestent au même moment, soit environ un mois après l'arrivée du bébé.

De plus, les deux groupes semblent étroitement liés. Au moins la moitié des pères souffrant de DPP

sont avec des partenaires qui en souffrent aussi. Cela signifie que dans un nombre important de foyers touchés par la DPP, les deux adultes souffrent.

La deuxième raison est la suivante : la DPP touche aussi les enfants.

Pendant les deux ou trois premières années de vie, les connections neurales se multiplient à un rythme de plusieurs millions à la seconde, bien au-delà de ce dont l'enfant aura besoin, ce qui permet au cerveau de se développer et de s'adapter à l'environnement. Cette capacité d'adaptation, appelée « plasticité neuronale », diminue avec l'âge. Les connections les plus utilisées se consolident et se renforcent et celles qui sont inutilisées s'étiolent et rétrécissent. Grâce à cette brève fenêtre d'adaptabilité phénoménale, les enfants peuvent apprendre des procédures complexes, comme les habiletés motrices et le langage, à une vitesse incroyable.

Malheureusement, cet état les rend aussi vulnérables à l'anxiété, la frustration et le stress émotionnel causés par la dépression. Ces problèmes s'enracinent dans leur esprit malléable, comme des doigts dans une pâte à modeler, et pourraient ne jamais totalement disparaître. Par conséquent, les enfants de parents souffrant de dépression sont plus à risque de vivre des problèmes sur le plan émotionnel, intellectuel et comportemental, surtout si les deux parents sont souffrants.

Parfois, ces symptômes prennent des années à se manifester. Selon une étude, un enfant de deux ans dont la mère souffre de dépression est plus à risque de vivre de l'anxiété à l'âge de 11 ans. Si un tel trouble apparaît, il risque de perdurer. La DPP est lié à des problèmes de colère et de renferment sur soi à l'étape de l'enfance, ainsi qu'à l'agressivité, l'anxiété, un QI plus faible chez les enfants d'âge scolaire, la consommation de substances, l'alcoolisme et le TDAH chez les adolescents.

Ces troubles exercent souvent un impact qui peut entraver la réussite plus tard. Ces futurs adultes risquent d'être peu scolarisés, de vivre dans la pauvreté et d'être atteints de troubles mentaux et physiques.

Vu ces conséquences à long terme, il est impératif d'élaborer un système proactif pour soutenir les mères et les pères qui souffrent de DPP. Un dépistage postanal exhaustif permettrait aux cliniciens en formation de repérer les individus qui pourraient en souffrir, et la présence d'un réseau d'intervenants professionnels et de groupes de pairs pourrait aider les parents à gérer les symptômes de DPP avant que leur état ne dégénère, tout en brisant le sentiment d'isolement.

Ce programme est bien plus qu'une simple aide aux parents. La mise en place d'un solide système de soutien prénatal et postnatal, non seulement pour les personnes atteintes de DPP mais aussi pour tous les parents aux prises avec la pauvreté, la toxicomanie et des problèmes psychologiques, donnerait aux enfants qui seraient à risque la possibilité de s'épanouir.

Les parents ne font pas qu'élever des enfants. Ils élèvent la prochaine génération de travailleurs, d'innovateurs et de leaders. En les aidant, nous aidons les enfants, notre société et nous-mêmes.

La DPP n'est pas seulement un problème qui nécessite une solution d'abord familiale, mais celle-ci est un bon départ. Un soutien aux parents en difficulté est un investissement pour un avenir meilleur.

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renting, *récemment paru aux éditions Dundurn Press.*

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Time for another look at the social factors that affect our health

How looking "upstream" can help Canada tackle complex social issues

RYAN MEILI

Healthcare is only one element of what can make a significant difference in health outcomes, with social factors, such as education or affordable housing or a safe working environment, playing a much more significant role in determining whether we will be healthy or ill. This has been understood for centuries, and in recent decades, has been empirically validated with study after study clearly demonstrating health inequalities between wealthy and disadvantaged populations.

Yet political conversations still tend to fall into familiar traps. If we talk about health we return by reflex to doctors and nurses, hospitals and pharmacies. And when we talk about politics — the field of endeavour with the greatest impact on what determines health outcomes — we too often insist the social factors that affect health, such as poverty or inequalities, are too complex or expensive to tackle.

We get stuck, in other words, and it appears there is no way out of the impasse.

To imagine a different approach, it's helpful to start with a classic public health parable. Imagine

you're standing on the edge of a river. Suddenly a flailing, drowning child comes floating by. Without thinking, you dive in, grab the child, and swim to shore. Before you can recover another child comes floating by. You dive in and rescue her as well.

Then another child drifts into sight…and another…and another. You call for help, and people take turns fishing out child after child. Hopefully before too long some wise person will ask: Who keeps chucking these kids in the river? And they'll head upstream to find out.

Every time we have to clean up an environmental disaster, every time a young person winds up in jail, every time people have to take medicines to make up for the fact that they couldn't afford good food, we're suffering from the results of downstream thinking.

Thinking upstream means making smarter decisions — long-term decisions — about what kind of country we want. What better goal than creating the conditions for all people to enjoy true health — complete physical, mental, and social well-being? And what better measure of a country's success than the health of its people?

First, we have to see beyond healthcare to what really makes us ill or well — income and its distribution, education, employment, social supports, housing, nutrition and the wider environment — the social determinants of health. Examining our decisions through the lens of optimal health allows us to focus our efforts on what makes the biggest difference to our well-being.

This also allows us to stop seeing investment in people as a cost. When we take into account the economic and social benefits of a healthy, educated population, we see that by doing nothing to address the factors that make people sick, we ensure that more and more kids will come down the river, and that many of them will drown.

A new national, non-partisan organization launching this month seeks to bring forward a new way of talking about politics in Canada. Upstream is a movement to change the current conversation. It aims to make the mainstream look upstream, helping citizens to demand a healthy society, and to understand the best ways to get there.

Upstream seeks to propagate a new frame, one that focuses in on the decisions that will make the most impact on the quality of our lives. By gathering the best evidence available, academics and advocates will promote decisions made on the basis of practicality rather than ideology.

Using storytelling through multiple forms of media, Upstream will help to bridge the gap between knowledge and practice. By connecting individuals and partner organization through common language and goals, Upstream can help to create public demand for language and ideas consistent with the new frame, and can ultimately open up the space for action on the part of citizens and governments to build a truly healthy society.

The evidence is clear, addressing the social determinants of health is essential to improving our lives. Too often, however, the immediacy of acute care distracts decision-makers from upstream investment to prevent ill health. By seeking to prepare, rather than waiting to repair, we can make wiser decisions and enjoy better lives.

For more information on Upstream: Institute for a Healthy Society, visit: www.thinkupstream.net

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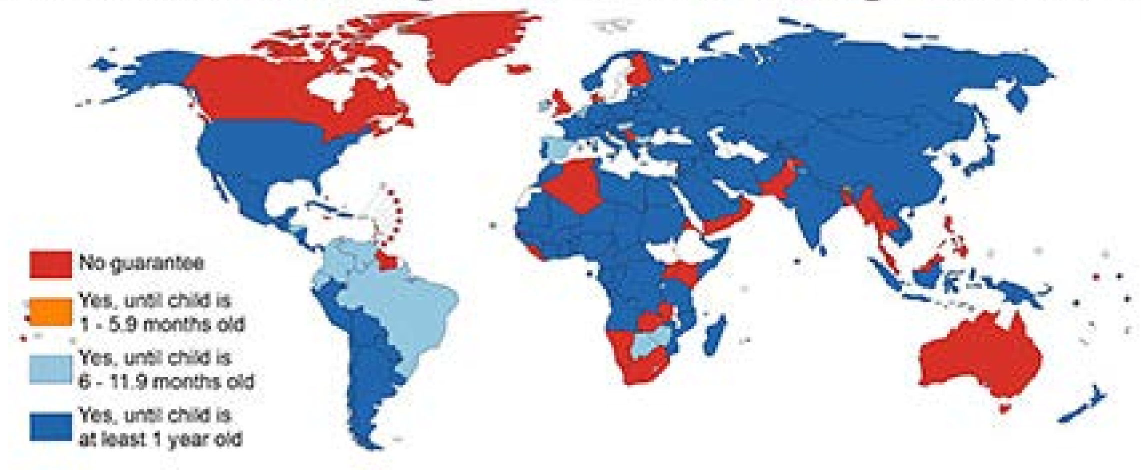
Why breastfeeding breaks for working moms pay off

Canada is in the minority of countries globally that do not guarantee paid breastfeeding breaks

JODY HEYMANN



How many new moms in Canada and the U.S. will be able to participate in national breastfeeding week (October 1–7)? In Canada and in the U.S., each for different reasons, it's up to their employers. In most of the world, mothers and their children don't need to rely on chance.

Sicty-four percent of Canadian women with an infant or toddler are in the labour force, as are 60 percent of moms in the U.S. Yet neither nation ensures that working moms have the basic rights they need to care for their own health and that of their infants from day one — and both countries could afford it.

The good news is that Canada guarantees 15 weeks of paid maternity leave. Equally important, women and men have a chance to start their family and work lives on a near equal footing because Canada guarantees 35 weeks of paid leave that can be taken by either parent. This places Canada ahead of more than three-quarters of the world's countries.

This is in sharp contrast to the U.S., which is near the back of the pack. The U.S. provides no paid maternity leave, making it one of only seven countries in the world failing to do so. Paid maternity leave brings with it many benefits, including increased chances for a newborn to have one-on-one care, increased likelihood that women will breastfeed and opportunities for parents to transition to their new role and form close relationships with their newborn.

But that's where Canada stops being progressive. One of the most common reasons that women stop breastfeeding is that they return to work. But working does not have to lead to lower rates of breastfeeding. The quantity and nutritional quality of breast milk are not undermined by maternal work or activity, including vigorous exercise. This is not about biology, it's about not having the time, place or chance to breastfeed or express milk.

In Canada, there is no guaranteed right for working mothers to take short breaks from work to breastfeed or express milk (although some human rights commissions have interpreted barriers to breastfeeding as gender discrimination).

Canada is an outlier — paid breastfeeding breaks are guaranteed in 130 countries and unpaid breaks in an additional seven. Since the passage of the Affordable Care Act, even the U.S. makes this guarantee.

Earlier this year in the journal of the World Health Organization, I published a study with my colleagues that concludes breastfeeding breaks work. Our research shows that the guarantee of breastfeeding breaks for at least six months is associated with a significant increase in the number of women practicing exclusive breastfeeding.

It doesn't cost much. It's hard to think of a workplace that can afford to give workers a lunch break but cannot find a way to give mothers a break to feed their infants. In fact, it's hard to think of a cheaper way to promote health.

Breastfeeding is an important health promoting step both for women's health and that of their infants — it lowers the risk of diarrhoeal disease in the baby by four to 14-fold and it lowers the risk of respiratory illness by five-fold.

Although the absolute benefits are greater in low-income countries, the risk of these illnesses is significantly reduced by breastfeeding in high-income countries as well — studies in affluent and poor nations alike have shown 1.5- to five-fold lower mortality rates among breastfed infants. Moreover, breastfeeding is associated with lower rates of chronic diseases such as diabetes and inflammatory bowel disease, and with improved brain development.

Moms do better too. Women who breastfeed have longer intervals between births and, as a result, a lower risk of maternal morbidity and mortality, as well as lower rates of breast cancer before menopause and potentially lower risks of ovarian cancer, osteoporosis and coronary heart disease. As a result, the World Health Organization recommends exclusive breastfeeding for at least six months.

There are moms who choose not to breastfeed, moms who aren't able to breastfeed for health reasons, or who have difficulty in doing so. But the overwhelming majority, 85 percent of Canadian moms, do start breastfeeding. The question is whether they have the chance to continue — when it brings such returns to both woman and child.

Paid breastfeeding breaks make good health and economic sense. So, which province is going to lead the pack in Canada — and follow much of the world — with a policy that provides some of the cheapest, most effective health benefits of any?

Dr. Jody Heymann is an expert adviser with EvidenceNetwork.ca and dean of the UCLA Fielding School of Public Health. Prior to becoming dean, Dr. Heymann held a Tier 1 Canada Research Chair in Global Health and Social Policy at McGill University.

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Les pauses allaitement sont rentables pour les travailleuses

Le Canada fait partie d'une minorité de pays qui ne garantissent pas encore le droit à des pauses rémunérées pour l'allaitement

JODY HEYMANN

Nous avons tous droit à une pause déjeuner au travail; les nourrissons, eux, ont-ils accès au repas le plus nutritif qui soit?

Soixante-quatre pour cent des Canadiennes et 60 pour cent des Américaines qui s'occupent d'un nourrisson ou d'un bambin font partie de la population active. Pourtant, ni le Canada, ni les États-Unis n'accordent aux mères au travail un droit élémentaire qui leur permettrait de veiller à leur propre santé et à celle de leur enfant dès sa naissance, alors que les deux pays en ont les moyens.

La bonne nouvelle pour les premières, c'est que le Canada garantit un congé de maternité payé de 15 semaines et le Québec, jusqu'à 18 semaines. Fait tout aussi important, hommes et femmes ont la chance d'être traités sur un pied de quasiégalité lorsque vient le temps d'entamer leur vie familiale et professionnelle : l'un ou l'autre parent a droit à un congé rémunéré de 35 semaines. (Le Québec accorde un congé parental de 32 semaines, en plus d'un congé de paternité de cinq semaines). Ce sont là de meilleures dispositions que celles qu'on trouve dans les trois quarts des pays du monde.

Ces mesures tranchent nettement avec la situation qui prévaut au sud de la frontière. En effet, les États-Unis arrivent pratiquement en queue de peloton : ce pays n'a pas adopté le congé de maternité rémunéré et figure parmi seulement sept pays dans le monde à ne pas l'avoir fait. Or il s'agit d'une mesure qui offre de nombreux avantages, car elle augmente notamment les chances que le nouveau-né reçoive des soins personnalisés, que sa mère l'allaite et que ses parents s'adaptent bien à leur nouveau rôle et établissent un lien étroit avec leur bébé.

Malgré tout, le congé de maternité seul ne peut suffire à assurer le bien-être des nourrissons. Le retour de la mère au travail signifie le plus souvent la fin de la période d'allaitement. Or le fait de travailler ne devrait pas nécessairement conduire à un faible taux d'allaitement. Le travail ou l'activité ne font pas baisser la quantité ou la qualité du lait maternel, ni même l'exercice vigoureux. Ce n'est pas une question de biologie, mais plutôt un problème associé au manque de temps ou de cadre propice pour allaiter et tirer son lait. Il faut donc accorder aux femmes les conditions requises, soit du temps et un espace dédié à ces tâches, ainsi qu'une garderie à proximité de leur lieu de travail ou un endroit pour conserver le lait maternel.

Au Canada, il n'existe pas de disposition qui accorde aux travailleuses le droit de se prévaloir de courtes pauses pour allaiter ou tirer leur lait (et cela même si certaines commissions des droits de la personne ont déterminé que les obstacles à l'allaitement maternel constituaient une forme de discrimination fondée sur le sexe).

Le Canada fait figure d'exception à cet égard; dans 130 pays, les femmes ont droit à une pause allaitement rémunérée et dans sept autres, à une pause non rémunérée. Même les États-Unis ont emboîté le pas depuis l'adoption de la réforme de la santé.

Au début de l'année, mes collègues et moi avons publié dans la revue de l'Organisation mondiale de la santé une étude confirmant que les pauses réservées à l'allaitement donnent des résultats. Selon nos recherches, le fait d'y avoir accès pendant une période d'au moins six mois contribue à une augmentation notable du nombre de femmes qui s'engagent dans l'allaitement exclusif.

C'est une mesure qui ne coûte pas grand-chose. Il est difficile de croire qu'un milieu de travail capable d'accorder une pause repas à ses employés ne puisse pas trouver un moyen d'accorder aux femmes une pause allaitement. En fait, on peut difficilement trouver façon moins chère de promouvoir la santé.

L'allaitement est une mesure importante dans la promotion de la santé des femmes et des enfants. Il diminue de quatre à quatorze fois le risque de maladies diarrhéiques chez le nourrisson; le risque de maladie respiratoire est divisé par cinq.

Même si ses avantages absolus sont plus nombreux dans les pays à faible revenu, l'allaitement réduit aussi de façon marquée les risques de maladie dans les pays à revenu élevé. Les études menées dans les pays riches et pauvres montrent que le taux de mortalité est de 1,5 à cinq fois plus bas chez les enfants nourris au sein. De plus, l'allaitement est associé à des taux plus faibles de maladies chroniques comme le diabète et la maladie inflammatoire chronique de l'intestin, ainsi qu'à un meilleur développement du cerveau.

Les mamans s'en portent mieux elles aussi. Chez les femmes qui allaitent, l'intervalle entre les grossesses est plus long, ce qui se traduit par une diminution de la morbidité et de la mortalité maternelles; le taux de cancer du sein avant la ménopause est plus faible et le risque de cancer de l'ovaire, d'ostéoporose et de coronaropathie serait potentiellement moindre.

Il y a des mères qui décident de ne pas allaiter, d'autres qui ne peuvent le faire pour des raisons de santé et d'autres encore pour qui c'est difficile. Malgré tout, la grande majorité des Canadiennes (85 pour cent) allaite dans les premiers temps. La question est de savoir si on leur donnera la possibilité de continuer, quand on connaît tous les bienfaits de cette pratique pour elles-mêmes et leurs enfants.

Du point de vue sanitaire et économique, les pauses allaitement tombent sous le sens. Alors, quelle province ouvrira la voie en adoptant une politique susceptible d'engendrer à un moindre coût des

retombées parmi les plus avantageuses en matière de santé, à l'image de ce qu'ont fait tant d'autres pays?

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Another kind of poverty

Lack of intellectual and emotional support hurts children's chances for success

Nicole Letourneau and Justin Joschko

More than one in seven Canadian children currently lives in poverty. That number has climbed steadily since the 1990s, and comes with very real consequences — both social and economic.

Children raised in poverty suffer from a disproportionate amount of health problems, have less education and are more likely to live in poverty as adults. This in turn hurts our economy as we struggle with higher rates of crime and joblessness, steeper healthcare costs, fewer income taxes and a sagging social safety net.

All told, poverty has been calculated to cost Canada $72 to 84 billion a year — that's between $2,299 and $2,895 per Canadian annually.

Unfortunately, poverty is as complex as it is costly, and our attempts to eliminate it have met with limited success. Yet there is cause for hope. As we come to better understand why child poverty leads to such poor outcomes — what precise factors are at play — it becomes easier to develop real and lasting solutions.

In our newly published book, *Scientific Parenting* (2013, Dundurn), we highlight a recent meta-analysis that Nicole and her team published, analyzing the results of every study they could find that looked at the relationship between families' socioeconomic status and their children's intellectual and behavioural development. At first glance, poverty seemed to impact how well children behaved or did in school. But the closer the team looked, the weaker this connection became.

The true culprits were manifold, but most of them — such as home environment, parental attentiveness, discipline, community safety, postpartum depression, increased life stress, family support and exposure to violence — had to do with the quality of a children's home lives — or, more

specifically, with their parents. Regardless of the family's budget, children who had loving, engaged caregivers were better off than those who didn't.

Of course, poverty places many additional challenges on parents. When living in poverty, meeting even basic needs — food, clothing, shelter — can seem enough of a challenge, leaving little time and energy for the intellectual and emotional needs, which can be much harder to see and therefore much easier to ignore. Yet these needs, invisible or not, are vital to children's long-term development, and their absence causes untold damage.

In this sense, the greatest challenge children face isn't financial poverty, but relational poverty.

Relational poverty means a lack of intellectual and emotional support from caregivers. Interaction, affection and play provide vital stimulation to infants' brains, which grow at a rate unmatched by anything they will experience later in life. This neural growth spurt allows children to absorb new skills and behaviours with phenomenal speed. It also leaves them vulnerable to stress, as even small issues can leave deep prints in their pliable minds.

Supportive adults act as a sort of buffer, protecting young children's minds until their neural growth rate slows and their brains become more durable. The trouble is that children on the low end of the socioeconomic spectrum are less likely to get this support and more likely to encounter toxic levels of day-to-day stress, which is why poverty and poor outcomes for children often align.

But they don't have to.

Caregivers don't need great riches to support their children. A strong, supportive adult figure can help children overcome otherwise unhealthy environments. This figure need not even be the child's parents (though of course this helps). A grandparent, and aunt, a family friend, even a dedicated teacher can have a tangible, long-lasting impact on a child's development.

Studies have found that the one sure predictor for success among children from poor families was a strong relationship with an adult.

To prevent the social and economic consequences of child poverty, we need to work with poor families. Changing public policy to better address basic needs for job security, living wages and adequate housing is essential. From there, helping parents address conditions related to poverty, such as mental health problems and addictions, would also make a difference.

But just as important are programs targeted specifically at parenting.

We need a more proactive postnatal outreach system, one that teaches basic parenting and child-bonding skills, one that can reach out to parents at home if necessary, and can be tailored to the needs of different families. If we put such programs in place, more children from impoverished homes will gain the tools needed to break the cycle of poverty.

A better chance to succeed means a better opportunity to contribute. And as more children rise to the occasion, our country will grow stronger, happier, and more successful. And that helps all of us.

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Justin Joschko is a freelance writer currently residing in Ottawa. Their co-authored book, Scientific Parenting*, has just been released with Dundurn Press.*

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Une autre sorte de pauvreté

Les enfants privés du soutien intellectuel et émotionnel des proches qui en prennent soin risquent de moins réussir.

NICOLE LETOURNEAU ET JUSTIN JOSCHKO

Plus d'un enfant canadien sur sept vit dans la pauvreté. Ce chiffre augmente constamment depuis les années 1990 et comporte des conséquences très réelles, tant sur le plan sociale qu'économique. Les enfants qui grandissent dans la pauvreté souffrent d'un nombre disproportionné de problèmes de santé, sont moins scolarisés et sont plus à risque d'être pauvres lorsqu'ils seront adultes. Cette situation nuit à notre économie et entraîne une hausse des taux de criminalité et de chômage ainsi que des coûts dans le domaine de la santé, sans compter une perte des revenus d'impôts et la détérioration du filet de sécurité sociale.

Selon les calculs, la pauvreté coûte au Canada 72 à 84 milliards de dollars par année, ce qui représente annuellement entre 2 299 $ et 2 895 $ pour chaque Canadienne et Canadien.

Malheureusement, la pauvreté est aussi complexe que coûteuse, et nos tentatives de l'enrayer ont donné des résultats mitigés. Mais il y a de l'espoir. Au fur et à mesure que nous comprenons davantage les liens entre la pauvreté infantile et ses conséquences néfastes, notamment les facteurs déterminants, il est possible d'élaborer des solutions réelles et durables.

Dans notre livre nouvellement publié, intitulé *Scientific Parenting* (2013, Dundurn), nous proposons une récente méta-analyse publiée par Nicole et son équipe, qui se penchent sur les résultats de toutes les études recensées portant sur le lien entre la situation socioéconomique des familles et le développement intellectuel et comportemental de leurs enfants. À première vue, la pauvreté semble avoir un impact sur leurs comportements et leur performance à l'école. Mais ce lien diminue au fil des analyses.

Les véritables causes sont multiples, mais la plupart des facteurs, comme le milieu familial, l'attention parentale, la discipline, la sécurité au sein de la communauté, la dépression postpartum, la présence d'un taux de stress élevé, le soutien familial et l'exposition à la violence, sont liés à la qualité de vie au sein du foyer, ou plus précisément aux parents. Peu importe le budget familial, les enfants ayant des proches qui prennent soin d'eux de façon aimante et engagée se portent mieux que les enfants qui en sont privés.

Évidemment, la pauvreté entraîne de nombreux défis supplémentaires pour les parents. En situation de pauvreté, la satisfaction des besoins, même de base, tels se nourrir, se vêtir, se loger, constitue un défi important. Il reste très peu de temps et d'énergie pour répondre aux besoins intellectuels et émotionnels, lesquels peuvent être difficilement cernables, voire invisibles. Toutefois, ces besoins, invisibles ou non, sont des éléments essentiels dans le développement à long terme des enfants. Une incapacité à répondre à ces besoins peut causer d'énormes préjudices.

De ce point de vue, le plus grand défi auquel font face les enfants n'est pas la pauvreté monétaire mais plutôt la pauvreté relationnelle.

La pauvreté relationnelle, c'est l'absence de soutien intellectuel et émotionnel de la part des proches qui prennent soin d'un enfant. Les interactions, l'affection et le jeu sont essentiels à la stimulation du cerveau du petit, lequel croît à une vitesse inégalée comparativement aux autres étapes de vie ultérieures. Cette poussée de croissance neurologique permet à l'enfant de développer de nouveaux comportements et habiletés à une vitesse phénoménale. Elle le rend aussi plus vulnérable au stress, des incidents mineurs pouvant laisser des marques profondes dans son esprit malléable.

La présence d'adultes soutenants agit comme une sorte de tampon et protège les jeunes enfants sur le plan psychologique jusqu'à ce que leur croissance neurologique ralentisse et que leur cerveau se stabilise. Le problème, c'est que les enfants qui sont situés sur l'extrémité faible du continuum socioéconomique risquent davantage d'être privés d'un tel soutien et de vivre des niveaux de stress quotidien toxiques, une réalité qui explique pourquoi pauvreté rime souvent avec piètres résultats chez les enfants.

Mais il peut en être autrement.

Les proches qui prennent soin des enfants n'ont pas besoin d'être riches pour leur apporter un bon soutien. Une figure adulte solide et soutenante peut aider un enfant à composer avec un milieu malsain. Cette figure peut être une personne autre que la mère ou le père (bien que ceux-ci soient en position d'exercer une influence positive). Un grand-parent, une tante, un ami de la famille, même une enseignante dévouée peut avoir un effet concret et durable sur le développement d'un enfant.

Des études démontrent que la présence d'un lien solide avec un adulte constitue un indicateur de succès fiable chez les enfants de familles pauvres.

Afin de prévenir les effets socioéconomiques de la pauvreté infantile, nous devons travailler avec les familles défavorisées. Il est impératif de changer les politiques publiques pour mieux répondre aux besoins fondamentaux en matière de sécurité d'emploi, de salaires et de logement. Il serait aussi utile d'aider les parents à composer avec certaines conditions liées à la pauvreté, comme les problèmes de santé mentale et de toxicomanie.

Il importe aussi de mettre sur pied des programmes qui portent particulièrement sur les compétences parentales.

Nous avons besoin d'un système d'approche postanale qui soit davantage proactif et qui enseigne les compétences de base nécessaire pour être parent et créer des liens avec l'enfant, un programme qui peut rejoindre les parents à la maison si nécessaire et qui peut être façonné selon les besoins de diverses familles. Si nous mettons de telles initiatives en place, un plus grand nombre d'enfants de foyers peu nantis acquerront les outils nécessaires pour briser le cycle de la pauvreté.

Une plus grande possibilité de réussir signifie une plus grande possibilité de contribuer. Plus les conditions favoriseront la croissance des enfants, mieux s'en portera la population de notre pays, qui sera plus forte, plus heureuse et plus épanouie, et plus le bien-être de notre collectivité s'améliorera.

Nicole Letourneau œuvre à titre d'experte-conseil auprès d'EvidenceNetwork.ca et est professeure aux facultés des sciences infirmières et de médecine. Elle est également titulaire de la chaire de la fondation Norlien/Alberta Children's Hospital œuvrant en santé mentale des parents et des enfants, à l'Université de Calgary. Justin Joschko est rédacteur pigiste et vit actuellement à Ottawa. Ils sont co-auteurs d'un livre intitulé Scientific Parenting*, récemment paru aux éditions Dundurn Press.*

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What the rest of Canada can learn from Winnipeg's new crime reduction strategy

Integrated social services and social development can help prevent crime

RICK LINDEN

In the recent federal throne speech, the Harper government proposed a law to ensure that people like Paul Bernardo will never get out of jail. Sounds good — except the truth is that he, and others like him, will almost certainly never get out of jail under current laws. In other words, it was nothing more than symbolic legislation that plays well to the general public.

Wouldn't it be better if the government put its energies behind supporting initiatives that would actually make Canadians safer? Communities across the country are not waiting on the federal government, and are doing just that. Winnipeg is a case in point.

Between 1991 and 2010, the crime rate in Canada's nine largest cities declined by a whopping 50 percent. In Winnipeg, the reduction was only 25 percent, much of which was due to an 85 percent decline in car theft. Violent crime and community safety have remained significant challenges for the city of Winnipeg.

But a new a new crime reduction strategy called "Block by Block" could significantly change this.

The Province of Manitoba, the City of Winnipeg, and the Winnipeg Police Service have developed partnerships with a broad range of social agencies and community groups that will establish one of North America's most comprehensive community safety and wellness initiatives, literally tackling the issues "Block by Block."

Three factors give Block by Block a good chance of being successful: integrated social service delivery; crime prevention through social development; and a new policing strategy.

First, Block by Block focuses on prevention and early intervention, modeled on the city of Prince Albert's Community Mobilization program. Prince Albert has reduced its once-soaring crime rates by over 40 percent, and has also seen reductions in emergency hospital admissions and social service referrals.

Winnipeg's program will bring together a broad range of agencies to deliver services to those at highest risk and in greatest need. Consider a 3 a.m. police response to a troublesome party house. The police called EMS to take an unconscious woman to the hospital. The police supervisor then had to decide what to do with three girls at the party in their early teens. No social agencies were open that late at night and he didn't want to detain them because their only offense was underage drinking. He spent considerable time trying to locate a responsible adult to look after them. This call involved three police cars and two EMS vehicles and police had no means of following up to ensure the same problems didn't arise at the same house the next day.

Block by Block will enable the police to work with other agencies to deal with problems like this one. Service delivery will be coordinated through a "Hub," a group including community agencies, child welfare, health, addictions, education, police and probation. This group will coordinate services to individuals and families. The Hub's goal is to intervene at an early stage before problems become serious.

Secondly, Block by Block will focus on crime prevention through social development. The LiveSAFE initiative is focused on improved housing, better access to wellness services, neighbourhood beautification and improved infrastructure.

Finally, a new policing strategy will better serve the area. The Winnipeg Police Service (WPS) will work with the community to deal with the issues underlying criminal behaviour because they know they cannot arrest their way out of the city's problems. The WPS are part of the Hub and are partners in LiveSAFE.

The WPS is also implementing a Smart Policing Initiative, focusing on hot spots — places with a high incidence of crime and disorder — and on high-risk individuals, rather than simply responding to calls for service. This approach has been proven effective elsewhere.

Reduced crime is one of the anticipated outcomes of Block by Block, but there may be other benefits, such as reduced emergency hospital admissions, reduced family service referrals, better educational outcomes and higher employment rates.

Other communities are implementing similar initiatives that will have real impact on safety. The federal government can carry on with its window dressing, while communities across the country are rolling up their sleeves and getting things done.

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This doctor treats poverty like a disease

An American health journalist visits Canada — and likes what she sees

Trudy Lieberman

What would you think if your doctor handed you a prescription that recommended filing your tax returns or applying for food or income benefit programs instead of the usual medicines for high blood pressure or diabetes? You'd probably say the physician was nuts. Tax refunds? Food? What do they have to do with making you healthier?

I just returned from a month long Fulbright fellowship in Canada and met such a physician, Dr. Gary Bloch, who practices family medicine at St. Michael's Hospital in Toronto. We had a long conversation about what makes people healthy. He wasn't interested in talking about new drugs to lower cholesterol hyped by the latest drug salesperson to walk through his door.

"We've created an advocacy or interventional initiative aimed at changing the conversation about poverty and how doctors think about poverty as a health issue," Bloch told me. "It's one of those cultural shift things. My job is to push ideas for physician interventions around poverty." Bloch showed me a clinical tool used by primary care practices in Ontario that is based on strong evidence linking poverty to bad health outcomes.

The tool, a four-page brochure, is simple in design but powerful in concept. "You come at poverty

from every possible angle," Bloch said. "You start from the evidence and frame the issue in language doctors can understand."

The evidence: Page one of the tool points out that "poverty accounts for 24 percent of person years of life lost in Canada (second only to 30 percent for neoplasms)," and notes that "higher social and economic status seem to be the most important determinants of health."

The tool: Three steps to address poverty in primary care practices.

Step 1: Screen everyone by asking, "Do you ever have difficulty making ends meet at the end of the month?" Using the language of clinical tests, the tool says that this question yields a sensitivity of 98 percent (the ability to predict the number of people with the disease) and a specificity of 64 percent (the ability to predict those without the disease).

Step 2: Factor poverty into clinical decisions like other patient risk factors. The tool provides examples, such as noting that a man living in the lowest quartile of poverty has twice the risk of diabetes as a high income man. Therefore, when a 35-year-old man comes to the office without risk factors for diabetes but has a very low or no income, doctors should consider ordering a screening test for the disease.

Step 3: Intervene by asking questions. Here's where that prescription to file your tax returns comes in. Bloch suggests asking if older patients have applied for all the supplemental income benefits they're entitled to or whether all patients have applied for drug benefits they may be eligible for.

While these seem pretty straightforward and useful, I wondered how many primary care docs in the U.S. have thought about asking similar questions. I don't know how many times I've heard physicians say they order prescriptions for expensive meds knowing that even cheap, basic antibiotics are out of reach for their patients. That's where the conversation ends, and so does care for those who need treatment.

I asked Bloch about the impact of his poverty tool, a simple paper brochure, in an age when the press, the public and the medical profession are focused more on shiny, new technology and drugs than the basics of life. He said this approach is "one of those snowball things that keeps rolling."

The Ontario Medical Association will soon publish a poverty intervention tool, and the Canadian Medical Association held town hall meetings earlier this year in several Canadian cities. Participants identified four main social determinants of health: income, housing, nutrition and food security, and early childhood development.

Put all this in the current American political context, which calls for cutting food stamps, making seniors pay more for their Medicare benefits, changing the calculation of the Social Security cost-of-living formula, and the lack of focus on early education and affordable housing. Contrast the latter with all the media hype about affordable healthcare. In the end, affordable housing may trump affordable healthcare if the objective is really better health.

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The great Canadian experiment to house the homeless

TRUDY LIEBERMAN

That health is more than healthcare was a point I heard many times on my recent Fulbright fellowship visit to Canada. Right now in the U.S., you'd never know that though, what with all the hullaballoo over dysfunctional websites and failed efforts to get more people covered by insurance. You'd think the only thing that matters is a cheap premium that somehow equates with good health outcomes.

Well, all Canadians have access to healthcare, but not every Canadian has good health, and on this trip I heard much more about the social determinants of health than about the country's infamous waiting lists. When I asked Canadian health expert Michael Decter, who served as a deputy health minister in Ontario, what his top priority was for Canadian healthcare, it wasn't reducing wait times for cataract surgery. It was addressing the poor health of the country's Aboriginal populations, which he called an embarrassment. "To fix this," he said, "the country must deal with poverty, diet, education and housing."

In the U.S. we don't often think about coupling housing with health, but Canada has. One project, At Home/Chez Soi, funded by the Canadian government, is a randomized controlled trial focused on housing for the mentally ill. At Home/Chez Soi is built around the concept that housing is the

first order of business, and then comes support services that honor a person's choices and offer a range of resources, says Dr. Paula Goering, a psychiatry professor at the University of Toronto who led the study.

At Home/Chez Soi provides housing to the mentally ill who need it to re-enter society, Goering noted in a post that she and colleague Stephen Hwang wrote for EvidenceNetwork.ca (a repository of studies that examine the evidence for various health policy interventions). They wrote that traditional housing solutions for the homeless, such as community programs and beds in shelters, "have not measurably reduced the number of homeless people country-wide," so the Canadian government looked for other cost-effective alternatives. "People don't like to live in group homes," Goering told me when I visited with her in Toronto a few weeks ago.

Some 2,250 homeless people in five Canadian cities enrolled in the program in 2011. Half of them received mostly private-sector housing; the other half got the usual community or shelter referrals. Those in the private sector group chose an apartment in a neighbourhood they liked, and the program provided the furniture. Participants contributed 30 percent of any monthly income they received toward the rent while subsidies from At Home/Chez Soi paid the remainder. They also had to agree to a weekly visit from a case manager.

To qualify for this housing initiative, individuals don't need a job or a stable lifestyle, and they don't need to enter rehab, Goering and Hwang wrote. However, those who had their own apartments started asking for additional help to keep their home and the stability, privacy and safety it offered, Goering noted.

What are the results so far? For people in their own apartments, "the quality of life is better and aspects of social functioning are better," Goering explained. "And they are using more services in the community than acute services." That could be a plus given that Canada is trying to shift care from costly acute care settings to care in the community, which frees up resources for the very sickest and trims wait times for elective surgeries. There is some evidence, Goering added, that use of emergency rooms is down, too.

While researchers expected to see different physical and mental health outcomes for the two study groups, they found improvement in both. The reasons: perhaps some participants who were in crisis at the beginning of the study returned to a more normal state anyway, or maybe the similar effects stem from what Goering calls "an accessible healthcare system that does serve both populations."

On the money side, the interim results point to cost offsets for other services. Goering added that "for every $10 spent on housing, $7 are saved in health and criminal justice costs." Researchers in Portugal, Australia, and France have looked at the program, and the French have started their own parallel study. What's next? The program is likely to continue with support from the federal government whose response to the project's success has been "quick and dramatic." Goering said the fact that the program was a randomized controlled trial strengthened researchers' voice in government. They had also hoped for support from the cities and provinces to continue the program, but that has been slower to achieve. Funding has been secured in two cities, is somewhat in place for two more, but not at all in the fifth one, Montreal.

Still, At Home/Chez Soi is an innovative approach to homelessness that reinforces the truism that good health is more than swallowing the latest wonder drug.

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Chapter 6: Aging Population

The real costs of long-term care for Canada

And the cost of doing nothing

MICHEL GRIGNON AND NICOLE F. BERNIER

As Canada's population ages, a growing number of frail seniors will require long-term care services to help them perform daily activities such as eating, dressing or bathing. Ensuring that adequate care is accessible to every Canadian who needs it should be a national priority.

But who should foot the bill?

The cost of long-term care services can be very high: 24/7 assistance in an institution costs around $60,000 per person per year. At present, the financing of long-term care in Canada is a patchwork. Access to long-term care and its cost to individuals vary depending on the region where they live and whether they are still at home or in a residential facility.

In a study published earlier this year by the Institute for Research in Public Policy, we reviewed the theory and practice of long-term care funding to determine what method would best suit Canada.

We found that relying on private savings is not an efficient way for Canadians to provide for their potential future care needs, since individuals are likely to save too much or too little. The risk of becoming dependent on formal care for an extended period of time is concentrated among a relatively

small segment of the population for whom the risk can reach catastrophic levels in financial terms. For example, at age 65, only 20 percent of individuals will require care for more than five years in their remaining years.

On average, individuals would need to save the equivalent of $7,500 per year over a 40-year period, a total of $300,000, to adequately prepare for their potential long-term care funding needs (married couples could halve this amount). So the private savings option is not only not feasible for most, it would also be a waste of resources, because 80 percent of the population will end up not needing so much savings.

In fact, in no country in the world are private savings the only source of funding for long-term care, not even in the U.S. or Singapore, two countries noted for their preference for individual savings and market competition in *healthcare*.

Our research found the best way to guarantee that adequate long-term care and assistance will be available to every Canadian who needs it at a reasonable cost to society is through comprehensive, public, universal, compulsory and standardized insurance coverage. In other words, a public long-term care insurance plan, along the lines of what medicare already does for medical care in Canada, is the most desirable option.

Public long-term care insurance is the best option for two reasons. First, insurance is essential because private savings is not an efficient way for individuals to provide for their potential future care needs, as we have already stated. It makes good sense to have the lucky ones (those who can live independently) transfer resources to those needing care.

Second, insurance must be public, and not a mixture of public and private, or private. Private and public insurance cannot be combined because if there was a public means-tested program, there would be no incentive for individuals to purchase private insurance. Hence, a private-public mix would fail to produce universal coverage.

Private insurance alone will not result in universal coverage either. Data from the OECD indicate that private long-term care insurance is not widespread in wealthy countries. Less than one percent of Canadians and less than 10 percent of Americans have long-term care insurance contracts. There are many possible reasons for this: perhaps people do not think they will require long-term care 20 or 30 years in advance of the need, and perhaps the premiums charged for long-term care coverage are too high because companies need to balance systemic risk (the significant time lapse between premiums collected and payouts).

So the best option is a public insurance scheme with a single payer that provides benefits based on a standardized evaluation of care needs. This would ensure that all Canadians have better care and that access to long-term care services is more equitable. With a universal public insurance plan transaction costs and loading fees would be lower, so it would also be less expensive than private insurance.

Overall, a universal public insurance plan would be far better than the fragmentary systems we have at present, which poorly serve those Canadians who need them most, often at the greatest cost.

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Why we need an improved and sustainable CPP

It's time for Canada's finance ministers to think outside the box

Michael Wolfson

Canada's finance ministers have just concluded another meeting postponing — yet again — improvements to the Canada (and Quebec) Pension Plan.

The same tired conflicts are still at work: the business community is opposed to higher payroll taxes, or to the enlargement of the public sector for any reason; while progressive voices, as well as those simply examining the available evidence, are rightly concerned that Canadians are not saving enough for retirement.

Even Minister Flaherty, for a time two years ago, agreed that a "modest expansion of the CPP" was good policy.

But the Harper government decided instead to introduce voluntary Pooled Retirement Pension Plans, even though decades of experience with enlarged RRSP contribution room still shows most middle income Canadians choose not, or find themselves unable, to save as much as these generous tax incentives already allow.

The evidence is clear: if middle income Canadians want to have adequate incomes in retirement,

they have to force themselves to save. The most efficient way to do this, by far, is to work together — to legislate individual contributions to a broadly-based program that pays retirement benefits when we get old; in short, the CPP.

Minister Flaherty, in objecting to enlarging the CPP, is worried that expanding CPP benefits payable sometime in the future, accompanied by an increase in contributions today, would be risky for the economy overall.

But how much tax increase are we talking about?

The Canadian Labour Congress proposal is to double CPP benefits as a fraction of pre-retirement earnings, from 25 percent to 50 percent. Payroll taxes would then have to increase by about five percentage points (combined employee and employer contributions, covering only current service costs, and CPP benefits payable only after age 65).

Interestingly, when the CPP contribution rate was increased by an even larger amount in the 1990s to make the plan fiscally sustainable — from 3.6 percent to 9.9 percent, an increase of 6.3 percentage points — there were no loud objections from the business community or fiscal conservatives.

Other proposals involve increasing the maximum earnings eligible for CPP benefits, and on which contributions are payable, beyond the current $50,000. Some combination of increasing the benefit rate above 25 percent, and increasing covered earnings beyond $50,000, is essential for the CPP to provide more adequate retirement income.

Still, this debate about CPP expansion is too limited. Are there no more creative options?

Consider three other major factors: First, life expectancy has been increasing by about two years every decade since at least the 1950s. This means that by the time any expansion of the CPP is fully phased in, life expectancy could be as much as 10 years higher than it is today.

Second, the detailed simulation analysis I did last year for the Institute for Research on Public Policy (IRPP) showed that a doubling of the CPP would have only modest benefits even for those at the young end of the baby boom (those in their mid-40s today). The simple reason is that they will be reaching age 65 within 20 years, when the benefit increases would be less than halfway phased in. And third, high income individuals live and collect CPP pensions longer than those with middle and lower incomes.

These factors in turn suggest essential policy responses, none of which has yet been addressed by Canada's finance ministers, at least in public.

An expansion of the benefit levels of the CPP should be phased in more rapidly, say over 20 to 25 years rather than the 47 years implicit in all the current discussions. In parallel, the age at which full benefits from the CPP would start should rise gradually from 65 to 70. More rapid phase in of benefits, of course, means payroll taxes would have to rise. But a delay in the age when benefits become fully payable would reduce the need for tax increases.

Finally, the long run structure of the Old Age Security (OAS) and Guaranteed Income Supplement (GIS) portions of Canada's public pension system should be coordinated with any changes to CPP to assure it is fair to those with lower incomes — a point clearly lost on the Harper government with their most recent cuts to OAS and GIS. These options open the possibility of a more creative and better pension bargain — more adequate pensions that are also fiscally sustainable. Are Canada's finance ministers ready to think outside the box?

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Baby boomers looking to right public healthcare, not drain it

Should we baby boomers be feeling guilty now that everyone else seems to have finally clued in to the developed world's worst-kept secret: there are lots of us, we didn't have enough children of our own to replenish the taxpayer base, and we didn't contribute enough in taxes to cover our future health needs as increasingly frail citizens?

Result: our children and theirs are going to be saddled with an expensive burden they can ill afford as droves of silver-haired boomers leave the workforce and consume a disproportionate share of public health resources in their senior years.

The situation is dire if you believe author Jeffrey Simpson. In *Chronic Condition: Why Canada's Health-care System Needs to be Dragged Into the 21st Century*, Mr. Simpson notes that slower economic growth in the decade ahead will coincide with an aging Canadian population. He notes that wringing efficiency gains out of medicare will almost certainly not be enough to sustain it. He backs this up with evidence in 2010 from the OECD that "Canada could (only) lower by 2.5 percent its spending on healthcare were the Canadian healthcare system to become as efficient as the best in the OECD." This suggests we must be prepared to increase taxes, introduce parallel private services and user fees, or cut public services.

Simpson's conclusion misses an important element — actually five important elements. Safety, effectiveness, appropriateness, accessibility and acceptability. Each of these dimensions of healthcare has an impact on cost. Examining a sixth dimension — efficiency — alone, to the exclusion of the others, will miss the opportunity to squeeze significant value out of our public health dollars.

Let's look at access, for example. Patients who wait long periods for surgery consume healthcare resources to manage their symptoms, like pain, while waiting; the longer they wait, the higher the symptom management costs. A report prepared for the Canadian Medical Association in 2008 put the total cost of excessive waits for total joint replacement at $26,400 per patient.

How about safety issues? Better risk management of patients can reduce the chances of infections, blood clots and heart attacks that put patients back in hospital after surgery.

Appropriateness of care decisions are also cost drivers. Here, identifying "the right patients" could reduce the numbers who are routed to expensive testing and to a surgeon but do not require surgery. This is more common than most people realize, generating higher costs needlessly while increasing the waiting time for people who actually need the tests and surgery.

There are numerous examples of potential cost savings in each of the six dimensions of healthcare. The salient question is: are we doing anything about them?

In Alberta, a new concept has been launched that brings into play potential improvement in all of these dimensions. The concept, Strategic Clinical Networks (SCN), was launched in the summer with the first six of 12 high-volume, high-need areas of medicine: bone and joint health; obesity, diabetes and nutrition; seniors' health; cardiovascular health and stroke; cancer care; and addiction and mental health.

These SCNs bring together all of the healthcare constituents — health professionals, patients, researchers, academics, business people and policy-makers — in teams that have the opportunity to profoundly change the way services are designed and delivered, and to expand and exploit research and development of technologies.

Clinicians take on leadership roles in multi-stakeholder teams. Patients — the actual users — have a direct say in designing and delivering services. Business people bring a business perspective and entrepreneurial spirit to the table — and, as in industry, new ideas have to be supported by a rigorous business case. Results will be monitored and measured, a standard practice in business, which long ago recognized that improvement is impossible without measurement.

Much of this is the work of baby boomers who are approaching their retirement years with more than a few ounces of creative juice still flowing.

As for feeling guilty, well, boomers don't exactly have a history of feeling guilty about anything. But they do have a history of leading change. They have rocked, shocked and shaped the world like no generation before them. Don't rule out Canada's baby boomers righting public healthcare as one of their final acts of defiance against conventional thinking.

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How much is enough retirement income?

Canadian finance ministers to consider “modest CPP expansion”

Michael Wolfson

How much income would most of us consider enough during our retirement? Canadian finance ministers will implicitly give us their answer when they define a “modest Canada Pension Plan (CPP) expansion” at their next meeting in June 2013.

Canadians might be surprised to learn that more than half of middle income Canadians in their mid-40s today — with before-tax incomes between $35,000 and $80,000 — can expect a drop of at least 25 percent in their post-retirement consumable income, according to a recent study I conducted for the Institute for Research on Public Policy (IRPP).

Should this be a concern? How much do we really need for retirement?

Economists, in theory, have a ready answer: we generally try to arrange affairs so that our consumption stays level over our lifetime. While many practical realities come between textbook theory and the real world, the idea of smoothing out consumption opportunities between working years and retirement years is widely accepted.

For those with low incomes during their working years, though, avoiding poverty in old age is the

main criterion for retirement income adequacy. And Canada has led the world, with its Old Age Security (OAS) and Guaranteed Income Supplement (GIS) programs, where consistently for decades seniors have received incomes which kept them just above Statistics Canada's low income line.

But if OAS and GIS were the only source of income after retirement, those who had middle and upper level incomes during their working years would face a major drop in their living standards when they retired. This is where the second criterion for retirement income adequacy kicks in — "continuity of consumption." A post-retirement income is adequate in this sense when (after-tax, after saving and dis-saving) it allows levels of consumption to continue post retirement even though we've lost our income from working.

This principle has been central to the design of private pensions, and the advice wealthy individuals get from their financial planners. It was also well understood by the framers of the CPP when it was introduced in 1966.

The CPP, and the parallel Quebec Pension Plan, were not designed, though, to provide full continuity of consumption for everyone. They were introduced simultaneously with the GIS; the OAS and increasingly generous RRSP tax incentives were already there; many employers already offered company pension plans; a substantial majority of Canadians reached age 65 owning their own homes, usually free of mortgage, and the wealthy were expected to look after themselves.

The trouble is, we have known for decades that this collection of programs and individual initiatives has not been working well for many middle income Canadians.

During the "great pension debate," the Federal Government's Green Paper on pension reform in 1982 gave detailed estimates showing that anywhere between 20 and 50 percent of Canadians would fail to achieve full continuity of consumption, depending on whether one was talking about a five or a 25 percent point drop. The business community even arranged for a leading private sector actuary to audit the complex underlying analysis; they found no flaws.

But the CPP has not been enlarged and workplace pension plans have shrunk, though RRSP contribution limits have been greatly expanded. Yet, as noted above, the drop in consumption now projected after retirement is even greater.

There are many crucial judgments involved in determining whether a specific proposal for enlarging the CPP, with its projected impacts on future retirement incomes, is "modest" or mere tokenism. For example, should Canadians be expected to sell their house in order to finance their retirement? Is it OK to face a 10 percent decline in consumption after retirement; what about a 40 percent drop?

So far, ministers of finance have published nothing of their officials' analyses, let alone followed the example of the 1982 Green Paper, where a leading actuary was allowed to peer review the analysis. This lack of government transparency — a hallmark of our time — means Canadians are left in the dark — not only on the general outlines of the "modest CPP expansion" being discussed, but also, more fundamentally, the underlying judgments as to what an adequate retirement income means.

What has happened to open, accountable and evidence-based government?

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Protecting Canada's Seniors Act ignores the best evidence

More politics than good policy

Rick Linden and Arlene Groh

Crime issues are once again top of the federal government's agenda. Too bad none of the laundry list of unrelated pieces of legislation will have an impact on actual crime rates — nor will any of the proposed legislation assist the victims of crime.

It's more politics than good policy, in other words. And Canadians are losing out in the process.

Since 2006, the federal government has raised the mandatory minimum sentence for some gun crimes from four years to five years; imposed mandatory minimum sentences of nine months for those planning to sell six marijuana plants grown in a rented apartment; banned conditional sentences for people found guilty of stealing high-end television sets; and ensured that rehabilitated offenders have to wait five years longer before applying for a pardon.

There is no evidence that any of these laws, nor the myriad of other similarly random legislation passed by parliament, has made Canadians safer.

The Protecting Canada's Seniors Act, passed in December, is a particularly cynical piece of legislation. It purports to address elder abuse — a serious problem in Canada. Unfortunately, this act will

do nothing to protect seniors.

A glaring problem with the Act is that elder abuse cases are rarely reported to the police in the first place — it is largely a hidden crime — and offenders who have been reported are seldom convicted.

The legislative summary of the Act prepared by the Library of Parliament points out the sad truth: most elder abuse is committed by family members, and victims do not want family members charged. Other victims may lack the mental capacity to pursue a complaint, and in some cases of financial fraud, the victims do not even know they have been victimized.

But here's the real reason this Act should be treated like little more than political grandstanding — the new law adds virtually nothing to existing legislation. In fact, it is difficult to imagine an amendment to the criminal code that does less than this one.

The Criminal Code already required judges to take six specified aggravating factors into account in their sentencing. The new legislation simply adds a seventh factor: "evidence that the offence had a significant impact on the victim, considering their age and other personal circumstances, including their health and financial situation."

The bill does not refer to "elder abuse" nor does it specify any particular age at which the aggravating factor should apply. The legislative summary notes that many judges already take the age of the victim into account in sentencing.

If the government had wanted to protect seniors they could have followed several models of best practice, such as the Waterloo Region's Elder Abuse Response Team, a partnership between the Waterloo Region Police Service and the Community Care Access Centre. A detective constable and an elder abuse resource consultant work with a diverse group of partners including health and social services, justice, faith, and ethno-cultural communities to support abused seniors.

The team conducts joint investigations, facilitates linkages to community resources, and case manages situations until a community agency takes over or until the situation is resolved. The team approach allows for meaningful sharing of information to reduce the risk of harm for older persons. The barriers that prevent some victims from accessing police services are reduced by the sharing of information, collaboration within the community and the ability to call directly to team members.

The result: a dramatic 150 percent increase in the number of referrals in the first two years. Most of this increase involved cases of physical abuse, emotional abuse, neglect and self-neglect.

Less than 10 percent of referrals are dealt with by pressing criminal charges — which highlights why increased legal penalties will not have any impact on the incidence of elder abuse.

So, why should Canadians be concerned that legislation like Protecting Canada's Seniors Act is more symbolic than functional? Meaningless legislation diverts attention from the things that might actually help to reduce crime and to provide better services for victims.

The government should be focusing on what works — investing time and money in improving policing, implementing comprehensive programs such as the exemplary Elder Abuse Response Team, and providing more funding for victims, including seniors.

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Defined pensions largely a thing of the past

Longevity pensions provide a solution

ROBERT L. BROWN

The world of retirement income security is rapidly changing — and leaving most Canadians without a security net. In 1986, a sizeable 39 percent of the labour force had an employer-sponsored pension and most of these (92 percent) were Defined Benefit Plans, where workers knew clearly the income they would have post-retirement. By 2010, only 29 percent of workers had a workplace pension and only 75 percent of these were Defined Benefit Plans.

In the private sector, matters are even worse. Only 25 percent of private sector workers have a workplace pension and a little over half of these (56 percent) are Defined Benefit.

This means that of the private sector workers who are lucky enough to have workplace pensions at all, almost half (44 percent) have Defined Contribution type plans where the only thing that is known for certain is the size of the contributions going into a retirement accumulation fund. Normally, the worker is responsible for choosing how these funds are invested. And, when the worker retires, the "benefit" is the number of dollars in the fund, not a set monthly income.

For the remaining 75 percent of the private sector workers who have no workplace pension at all, they are dependent on their own RRSP savings. They have the dual challenge of choosing how to

invest these funds and then how to provide post-retirement income out of the funds.

If you are saving for your own retirement, one of the biggest issues is not knowing how long you are going to live.

It is true that one can buy a life annuity to remove this longevity risk, but they are an expensive option, largely because interest rates are at an all time low and insurance companies price workers on an assumed five-star life expectancy.

So, what's the solution?

In mid-April, the Government of Quebec released a report from an Expert Panel chaired by Alban D'Amours entitled: "Innovating for a Sustainable Retirement System." While the 220-page report contained a large number of proposals, there was one that was truly new and highly innovative. The proposal introduced the concept of "longevity pensions."

Here's how they work: If the Quebec government went forward with D'Amours' proposal, workers would contribute 1.65 percent of their earnings, matched by their employer, into a fund from ages 18 to 74 (no earnings, no contributions). Benefits would accrue on these same earnings at the rate of 0.5 percent per annum for a total potential benefit of 28.5 percent of credited earnings.

These benefits would become payable annually starting at age 75 and continue for life (but guaranteed for at least five years). Both contributions and benefit accruals would be capped at the Year's Maximum Pensionable Earnings (YMPE) or $51,100 today (indexed to wages).

To illustrate more clearly, a worker earning exactly the YMPE would contribute $843 a year (matched by the employer) and would be eligible for a pension of $14,564 per year (indexed) starting at age 75 and going for life (and guaranteed for at least five years).

For workers in a Defined Contribution or RRSP world, this proposal has huge potential. Instead of being forced to plan your retirement income to cover your unknown life expectancy, you could plan your drawdown much more accurately knowing that at age 75 an extra benefit of $14,564 per annum would kick in. This would be on top of your CPP, OAS, and possibly some GIS benefits.

Bottom line: Individuals would only have to provide their own retirement income from the point of retirement to age 75. But not to infinity as is necessary today (that is to some unknown limit defined by your life expectancy).

This idea deserves serious consideration by our federal government.

It could be enacted tomorrow without any approvals required from the provinces (unlike amending the Canada Pension Plan). And the infrastructure is already there: benefit administration could be assigned to the Canada Pension Plan and the investment of accruing assets to the Canada Pension Plan Investment Board.

Quebec has not yet endorsed the proposal. Predictably, it has been opposed by the Canadian Federation of Independent Business because their members do not want new expenses of $843 (per employee) a year. And you can expect opposition from the financial institutions who profit from your present dependence on their products.

That said, it is my sincere hope that Canadians can debate this innovative idea fully and openly. It deserves nothing less than that.

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Le régime à prestations déterminées est dépassé

La rente longévité offre une solution

Robert L. Brown

Le monde du revenu de retraite est en pleine mutation et la plupart d'entre nous sont maintenant sans filet de sécurité. En 1986, une part importante de la main-d'œuvre canadienne, soit 39 pour cent, bénéficiait d'un régime de retraite soutenu par l'employeur. La plupart de ces régimes (92 pour cent) étaient à prestations déterminées. Les travailleuses et travailleurs connaissaient donc le montant des prestations qu'ils allaient toucher à leur retraite. En 2010, seulement 29 pour cent de cette main-d'œuvre bénéficiaient d'un régime de retraite d'employeur, dont seulement 75 pour cent à prestations déterminées.

Dans le secteur privé, la situation est pire. Seulement 25 pour cent de ses travailleuses et travailleurs bénéficient de régimes de retraite soutenus par l'employeur et un peu plus de la moitié de ceux-ci (56 pour cent) sont à prestations déterminées.

Autrement dit, près de la moitié (44 pour cent) des travailleuses et travailleurs du secteur privé qui ont la chance de bénéficier d'un régime de retraite d'employeur adhèrent à des régimes à prestations déterminées, dont le seul facteur connu est le montant qu'ils contribuent à un fonds d'épargne-retraite. Normalement, la travailleuse ou le travailleur choisit la manière dont ces fonds sont investis, et

au moment de la prise de retraite, la « rente » est le montant d'argent contenu dans le fonds, et non un revenu mensuel déterminé.

Quant aux 75 pour cent des travailleuses et travailleurs du secteur privé qui ne bénéficient pas d'un régime de retraite d'employeur, ils dépendent des épargnes qu'ils ont faites dans le cadre du REER. Ils ont le double défi de choisir la façon dont ils investissent cette épargne et la façon d'en tirer un revenu à leur retraite.

Si vous épargnez pour votre retraite, l'un des facteurs inconnus avec lequel vous devez composer est votre longévité.

Certes, vous pouvez acheter une rente viagère pour éliminer le risque lié à la longévité, mais cette option est coûteuse, notamment parce que les taux d'intérêts sont plus bas que jamais et que les compagnies d'assurances prennent pour acquis que les travailleuses et travailleurs vivront très vieux.

Donc, quelle est la solution?

À la mi-avril, le gouvernement du Québec a publié un rapport d'un comité d'experts présidé par Alban D'Amours, intitulé : Innover pour pérenniser le système de retraite. L'une des nombreuses initiatives présentées dans le rapport de 220 pages est tout à fait novatrice et propose le concept de « rente longévité ».

Cette rente fonctionnerait de la façon suivante. Si le gouvernement du Québec mettait en œuvre l'initiative proposée dans le rapport D'Amours, les travailleuses et travailleurs verseraient 1,65 pour cent de leur revenu, et l'employeur une somme équivalente, dans un fonds, pendant la période de vie où ils auront entre 18 et 74 ans (pas de revenu, pas de cotisation). La rente serait capitalisée selon ces mêmes revenus, au taux de 0,5 pour cent par année, pour un remplacement total du revenu de 28,5 pour cent des revenus crédités.

La rente serait payable annuellement et à vie à compter de 75 ans (mais garantie pendant au moins cinq ans). La capitalisation tant des cotisations et que de la rente seraient assujetties à un plafond qui correspond au maximum des gains admissibles (MGA) pour l'année, soit 51 000 $ en 2013 (indexés sur les salaires).

À titre d'exemple, une travailleuse qui gagne exactement le MGA pour l'année contribuerait 843 $ par année (l'employeur fournissant une somme équivalente) et aurait droit à une rente annuelle de 14 564 $ (indexée) à partir de l'âge de 75 ans, à vie (et garantie pour au moins cinq ans).

Pour les travailleuses et travailleurs qui participent à un régime à prestations déterminées ou un REER, ce scénario offre un énorme potentiel. Au lieu d'être obligé de planifier votre revenu de retraite pour qu'il perdure pendant une durée de vie indéterminée, vous pourriez planifier votre prélèvement avec beaucoup plus de précision, en sachant qu'à 75 ans, vous bénéficieriez d'une rente supplémentaire annuelle de 14 564 $. Cette rente s'ajouterait à vos prestations du RRQ, de la SV et possiblement à un SRG.

Le résultat : les particuliers n'auraient qu'à assurer leur propre revenu de retraite du moment où ils cessent de travailler jusqu'à l'âge de 75 ans, et non jusqu'à la fin de leurs jours, comme c'est le cas aujourd'hui (plus précisément, jusqu'à une limite inconnue, selon votre espérance de vie).

Ce scénario mérite d'être sérieusement étudié par le gouvernement du Québec, qui n'a pas encore approuvé la proposition, et aussi par le gouvernement fédéral du Canada.

Contrairement à la plupart des changements apportés aux régimes de retraite, cette proposition

pourrait être adoptée au palier fédéral dès demain, sans que les provinces n'aient à donner leur approbation. De plus, l'infrastructure est déjà en place : la gestion des rentes pourrait être attribuée à la Régie des rentes du Québec et l'investissement des actifs capitalisés serait géré par la Caisse de dépôt et placement du Québec.

Comme on pouvait le prévoir, la Fédération canadienne de l'entreprise indépendante s'est opposée à la proposition puisque ses membres ne veulent pas débourser un montant supplémentaire annuel de 843 $ (par employé). Vous pouvez aussi vous attendre à ce que les institutions financières qui profitent de votre dépendance à leurs produits s'y opposeront.

Ceci dit, j'espère sincèrement que les Québécoises et Québécois, ainsi que tous les Canadiens et Canadiennes, participeront à un débat profond et ouvert sur cette approche novatrice.

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Not-so-modest proposals for improving the CPP/QPP

Half of middle-income Canadians over 40 will see a significant decline in their standard of living post-retirement

MICHAEL WOLFSON

Federal Finance Minister Jim Flaherty and his provincial counterparts, last December, agreed to consider options for a "modest" expansion of the Canada and Quebec Pension Plans in June 2013. June has come and gone without this meeting. If and when a meeting does occur, it will likely be behind closed doors, and Canadians will not know what kinds of "modest" expansion options are being discussed. However, if the rare tea leaves provided by finance ministers are any guide, Canadians nearing retirement shouldn't hold out much hope that these reforms will save the day.

In a study released on July 15 by the Institute for Research on Public Policy (IRPP), I have used Statistics Canada's Lifepaths model to project both the current retirement income system and some more out of the box options for meaningful reform. The projections show that about half of middle-income earners over 40 today will see a significant decline in their standard of living post-retirement. This may come as a rude awakening for many.

Most pension experts agree with Mr. Flaherty when he says: "Canadians are not saving enough for

their retirement." So what's the solution? All pension reform scenarios put forward so far assume that any new retirement benefits need to be fully pre-funded. This means it would take nearly half a century for any enhanced benefits to be fully phased-in.

Such a "modest" half-century solution won't help many Canadians. Clearly more creative thinking is needed. My new analysis for the IRPP provides detailed estimates for a series of options that effectively address the retirement income challenges Canada faces today.

First, and most importantly, the Canadian Pension Plan (CPP) and the Quebec Pension Plan (QPP) remain the best vehicles for reforming the retirement income system. If middle-income Canadians want secure and adequate incomes in retirement, voluntary plans won't do. They will have to force themselves to save more, and we all know this is unlikely to happen.

The most efficient and effective way for Canadians to save, by far, is to legislate the necessary earnings-based contributions to a broadly-based public fund; in short, the CPP/QPP.

If we expand CPP/QPP, then it is important to ensure that the reforms effectively target the problem at hand. Full pre-funding of benefit enhancements has been the universal, though implicit, assumption in all recent discussions — in order to ensure contribution rates remain stable and hence the long-run solvency of the fund.

But full pre-funding is not necessarily the only way to accomplish the twin objectives of plan solvency and rate stability. Increasing the age of pension eligibility, combined with an appropriate increase in the contribution rate to pay for these new benefits, would also produce financial stability. For many Canadians, these contribution rate increases would be smaller than those brought in during the 1990s, which had no obvious adverse effect on Canada's economy.

Increasing the eligibility age to between 68 and 70 (up from 65 today) would be sufficient to maintain financial stability while expanding and phasing-in new benefits more rapidly — over 20 years rather than nearly a half century. We could increase CPP retirement benefits from 25 to 40 percent of pre-retirement earnings above $25,550 (half the average wage) and double the range of covered earnings from $51,100 to $102,200 (twice the average wage).

It would also be possible within this framework to adjust benefits for lower-income earners to compensate for their lower than average life expectancy and their shorter time drawing retirement benefits. This would address the greater impact of raising the eligibility age on lower income groups.

Trading off a later pension age for enhanced CPP/QPP benefits, phased in over a shorter time horizon, is appealing on many levels. This "grand bargain" would significantly improve retirement incomes, do so sooner, encourage workers to remain in the labour force longer, and provide greater equity across income groups.

Taken together, these changes would reduce by a quarter the proportion of middle-income earners now facing a significant decline in their standard of living post-retirement.

These options are probably not "modest" amongst those long opposed to any CPP/QPP expansion, but they illustrate what is possible, and what is needed, if we are to avoid a wide-spread drop in Canadians' standards of living post-retirement.

It's time that our finance ministers finally and meaningfully address long-standing pension policy issues. Letting Canadians in on the discussions might be a good place to start.

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Patients receiving end of life treatments they don't want or need

Study reveals the importance of advance care planning

Sharon Baxter and Daren Heyland

Imagine, one day, without any warning, you find yourself in a hospital in a life-threatening situation, unable to communicate. Who would speak for you and make healthcare decisions on your behalf? That's a question that all Canadians need to contemplate — but recent studies indicate that most of us have not.

Advance Care Planning is a process of reflection and communication about personal care preferences in the event that you become incapable of consenting to or refusing treatment or other care. The most important aspects of advance care planning are choosing one or more Substitute Decision Makers — someone who will speak on your behalf and make decisions for you if you are not able to do so yourself — and having a conversation with them about your wishes.

In March 2012, an Ipsos-Reid national poll found that 86 percent of Canadians have not heard of advance care planning, and that less than half have had a discussion with a family member or friend about healthcare treatments if they were ill and unable to communicate. Only 9 percent had ever spoken to a healthcare provider about their wishes for care.

“People somehow have this superstition that if you talk about it, it might happen,” says Dian Cohen, an economist, author and journalist who counsels Canadians on personal money management. “But if we don’t speak up, how will others know how to help us? That’s an awful burden to leave behind.”

Healthcare professionals also seem reluctant to begin the conversation. The Advance Care Planning Evaluation in Elderly Patients (ACCEPT) study, an ongoing project managed by the Canadian Researchers at the End of Life Network (CARENET) that examines care for ill, elderly patients in acute care hospitals across Canada, has revealed a number of barriers to end of life discussions between doctors and patients — with the result being that many patients are receiving treatments they don’t necessarily want or need.

Results from the 2012 study, published in the April 2013 issue of the *Journal of the American Medical Association (JAMA) Internal Medicine*, found the correct patients’ preferences for end of life care showed up in their medical records only 30 percent of the time. Even though 28 percent of the studied patients stated a preference for “comfort care” (no life-sustaining treatments), this was documented in only four percent of their charts.

Many of the patients interviewed in the study felt that information to help them determine their preferences for end of life treatments was either lacking or not clear. “I didn’t know what he [the MD] was saying when asking me in the ER…. Do I want CPR,” recounted one ACCEPT study participant. “He asked with no explanation. I said, “sure if it works.” He put down YES on the form but then told me it probably wouldn’t work and I would have brain function problems. Good God! I don’t want that! Give me the information first, then ask the questions.”

Without a plan, patients can receive treatments that they don’t want, and families may find themselves having to make difficult decisions during a stressful time, or fighting with each other over those decisions. And for a strained health system and an aging population, a lack of planning can have a significant impact on health costs and resources.

Advance care planning doesn’t need to be difficult or depressing. The Advance Care Planning in Canada Project suggests five steps for creating your advance care plan:

- THINK about what’s right for you. What’s important to you about your care?
- LEARN about different medical procedures. Some may improve your quality of life, while others may not.
- CHOOSE a Substitute Decision Maker, someone who is willing and able to speak for you if you can’t speak for yourself.
- TALK about your wishes with your Substitute Decision Maker, loved ones and healthcare team.
- RECORD your wishes — write them down, record them or make a video.

As healthcare technologies and life saving interventions continue to improve and people live longer — many with complex medical conditions — advance care planning becomes increasingly important. We need to communicate our values and wishes around the use of certain procedures at the end of life, and around what we believe gives our life meaning. Make sure your voice is heard.

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Daren Heyland is an adviser with EvidenceNetwork.ca, a critical care doctor at Kingston General Hospital and a professor of Medicine and Epidemiology at Queen's University, Kingston. For over a decade, he chaired the Canadian Researchers at the End of Life Network, and currently, he is the principal investigator on two CIHR-funded studies looking at patient and family perspectives in advance care planning (the ACCEPT Study) and healthcare provider perspectives on the same topic in acute care settings (The DECIDE Study).

For more information about the ACCEPT study, visit the CARENET website at: http://www.thecarenet.ca

For more information about advance care planning, visit: www.advancecareplanning.ca

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De nombreux patients reçoivent des soins de fin de vie non désirés ou inutiles

Une étude révèle l'importance de la planification préalable des soins

Sharon Baxter et Daren Heyland

Imaginez qu'un jour, sans crier gare, vous vous retrouviez à l'hôpital dans un état critique, incapable de communiquer. Qui parlerait et prendrait les décisions relatives aux soins de santé en votre nom ? Tous les Canadiens et les Canadiennes doivent réfléchir à cette question, mais des études récentes montrent que nous sommes une majorité à ne pas l'avoir encore fait.

La planification préalable des soins est une démarche de réflexion et de communication concernant les préférences en matière de soins de santé dans l'éventualité où une personne deviendrait incapable d'accepter ou de refuser des traitements ou d'autres soins. L'un des aspects les plus importants de la planification préalable des soins consiste à choisir un mandataire (ou plusieurs) — c'est-à-dire une personne qui parlera en votre nom et prendra les décisions pour vous si vous n'êtes pas en mesure de le faire —, et à discuter avec cette personne de vos souhaits.

Un sondage national Ipsos-Reid effectué en mars 2012 a constaté que 86 pour cent des Canadiens n'avaient jamais entendu parler de planification préalable des soins, et que moins de la moitié avaient discuté avec un membre de leur famille ou avec un ami ou une amie des traitements médicaux qu'ils

seraient prêts à recevoir s'ils tombaient malades et étaient incapables de communiquer. Seulement 9 pour cent avaient déjà parlé à leur fournisseur de soins de santé de leurs volontés en matière de soins.

« Pour une raison ou pour une autre, les gens croient que si vous en parlez, cela peut arriver, affirme Dian Cohen, économiste, auteure et journaliste qui fournit des conseils aux Canadiens en gestion des finances personnelles. Cependant, si vous ne vous exprimez pas, comment les autres sauront-ils comment vous aider ? C'est un terrible fardeau à laisser derrière soi. »

Les professionnels de la santé semblent aussi réticents à amorcer la conversation. L'étude ACCEPT, un projet en cours du Canadian Researchers at the End of Life Network (CARENET) qui comporte l'examen des soins pour les patients âgés et très à risque de mourir dans des hôpitaux de soins de courte durée, a révélé un certain nombre d'obstacles aux discussions sur les soins de fin de vie entre médecins et patients dans différentes villes du pays — avec pour résultat que de nombreux patients et patientes reçoivent des traitements non désirés ou inutiles.

Les résultats de l'étude de 2012, qui ont été publiés dans le numéro d'avril 2013 du *Journal of the American Medical Association (JAMA) Internal Medicine*, ont montré que les préférences des patients en matière de soins de fin de vie figuraient correctement dans le dossier médical dans seulement 30 pour cent des cas. Même si 28 pour cent des patients participant à l'étude avaient indiqué leur préférence pour des « soins de confort » (sans traitement de survie), cette information figurait au dossier dans seulement four pour cent des cas.

De nombreuses personnes qui ont participé à l'étude ont senti qu'elles n'avaient pas obtenu d'informations pour les aider à établir leurs préférences en matière de traitements de fin de vie ou alors que les renseignements obtenus n'étaient pas clairs. « Je ne savais pas ce qu'il (le médecin) voulait dire lorsqu'il m'a demandé à l'urgence… Est-ce que je veux la RCR, se rappelle une participante à l'étude ACCEPT. Il m'a posé la question sans explication. J'ai répondu : "Bien sûr, si ça marche." Il a inscrit OUI sur le formulaire et m'a dit ensuite que ça ne donnerait probablement rien et que mes fonctions cérébrales seraient touchées. Bon Dieu ! Ce n'est pas ce que je veux ! Donnez-moi d'abord les renseignements puis posez-moi les questions ! »

Sans un plan préalable de soins, les patients peuvent recevoir des traitements qu'ils ne veulent pas avoir et les familles peuvent se retrouver à devoir prendre des décisions difficiles dans une période éprouvante ou se quereller concernant ces décisions. Le manque de planification dans le contexte de notre système de santé poussé aux extrêmes limites de ses capacités et de la population vieillissante peut avoir un grand effet sur les coûts et les ressources en santé.

La planification préalable des soins n'a pas à être difficile ou déprimante. Le projet La planification préalable des soins au Canada suggère les cinq étapes suivantes pour établir votre plan préalable de soins :

- PENSEZ à ce qui vous convient. Qu'est-ce qui est important pour vous relativement à vos soins?
- RENSEIGNEZ-vous sur les divers actes médicaux. Certains peuvent améliorer votre qualité de vie, d'autres, non.
- CHOISISSEZ un mandataire, soit quelqu'un qui est prêt à parler en votre nom si vous ne pouvez plus communiquer.

- PARLEZ de vos volontés à votre mandataire, à vos proches et à votre équipe de soins de santé.
- ENREGISTREZ vos volontés — écrivez-les, enregistrez-les ou faites-en une vidéo.

La planification préalable des soins est de plus en plus importante en cette époque où les technologies relatives aux soins de santé et les interventions assurant la survie ne cessent de s'améliorer et où les gens vivent de plus en plus longtemps. Nous devons faire connaître nos valeurs et nos volontés relativement à l'utilisation de certains traitements en fin de vie, et ce qui donne, pour nous, un sens à notre vie. Assurez-vous de faire entendre votre voix.

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Pour plus de renseignements sur l'étude ACCEPT, veuillez visiter le site Web du CARENET à http://www.thecarenet.ca.

Pour plus de renseignements sur la planification préalable des soins, veuillez visiter www.advancecareplanning.ca.

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Target Benefit Pension Plans are our future

ROBERT L. BROWN

Many papers carried an opinion article by Mark Milke of the Fraser Institute in mid-September. In this article, Milke notes that Canada now has a bifurcated pension world. Public-sector workers have very good Defined Benefit Pension Plans while the majority of private sector workers have no pension at all, and those that do tend to have Defined Contribution Plans where the worker carries all of the risks (e.g., investment risk, longevity risk).

But this bi-polar world will hopefully end in the foreseeable future. Every worker can have a decent Defined Benefit Pension Plan and taxpayers do not have to be on the hook for the ever-rising costs of public sector plans. The compromise solution is a Target Benefit Pension Plan model.

Provinces have already started to move in the direction of Target Benefit Plans to control costs and save taxpayers money.

Just this past week, Alberta announced changes to its pubic sector pension model. The main amendment is that annual cost of living increases will be paid only if the plans' finances permit. That is, this particular part of the benefit package will be dependent on the health of the pension fund at any moment.

New Brunswick has gone even further. None of their pension benefits, going forward, will be fully

guaranteed. Rather, the benefits that are being promised to the worker will initially be defined using a fairly conservative investment rate of return assumption. Based on this assumption, workers will be told what Target Benefit they should expect to receive upon retirement. If rates of return exceed the rate assumed, then benefits can actually be higher than first indicated or targeted. But, if investment returns are lower than anticipated (which should be a low probability event), benefits can actually be reduced. Thus, the risk of low investment returns is passed from the employer (the taxpayer) to the worker through this "contingent" benefit structure.

Amended pension regulation in Quebec would allow similar plans to exist in that jurisdiction.

Ontario has made moves similar to those being enacted in Alberta. For example, since 2009, the cost of living adjustment for the Ontario Teachers Pension Plan lies between 50 and 100 percent of the actual experienced cost of living increase. If the plan funding is healthy (e.g., 100 percent or higher) then a 100 percent adjustment for inflation will be made. But if the funding is not healthy (e.g., less than 100 percent), a smaller adjustment results. In 2010, the cost of living adjustment for the Teachers Plan was 60 percent of the actual cost of living increase (at a time when the plan was 97 percent funded).

British Columbia has had similar provisions in their public sector pension plans for over a decade. In B.C., cost of living increases are paid for out of an Inflation Adjustment Account. This account is funded by Defined Contributions from workers and the province (i.e.., taxpayers). If the fund can afford it, full cost of living adjustments are made, but if the fund is not able to pay a full adjustment, smaller adjustments are made. Because of this shift in the financing of the cost of living adjustment, the Plan liabilities for the Public Service Pension Plan in B.C. are only $18 billion rather than the $24.6 billon of liability that would exist if the cost of living adjustment were fully guaranteed.

We are now living in an unnecessarily bifurcated pension world. Public servants have very good Defined Benefit plans. The vast majority of private sector workers have no pensions at all, and those who do are normally in Defined Contribution plans where there are no benefit guarantees whatsoever. There is no need for this bifurcation and the pension envy that results.

Every worker in Canada could have a very good Defined Benefit plan without the employer facing unlimited funding risk. The way to achieve this is through Target Benefit Pension Plans such as the Shared Risk Plans of New Brunswick

The Provinces are already acting. It is time for the private sector to join the movement by offering their workers very good, but truly affordable, Target Benefit Pension Plans — the pension plans of the future.

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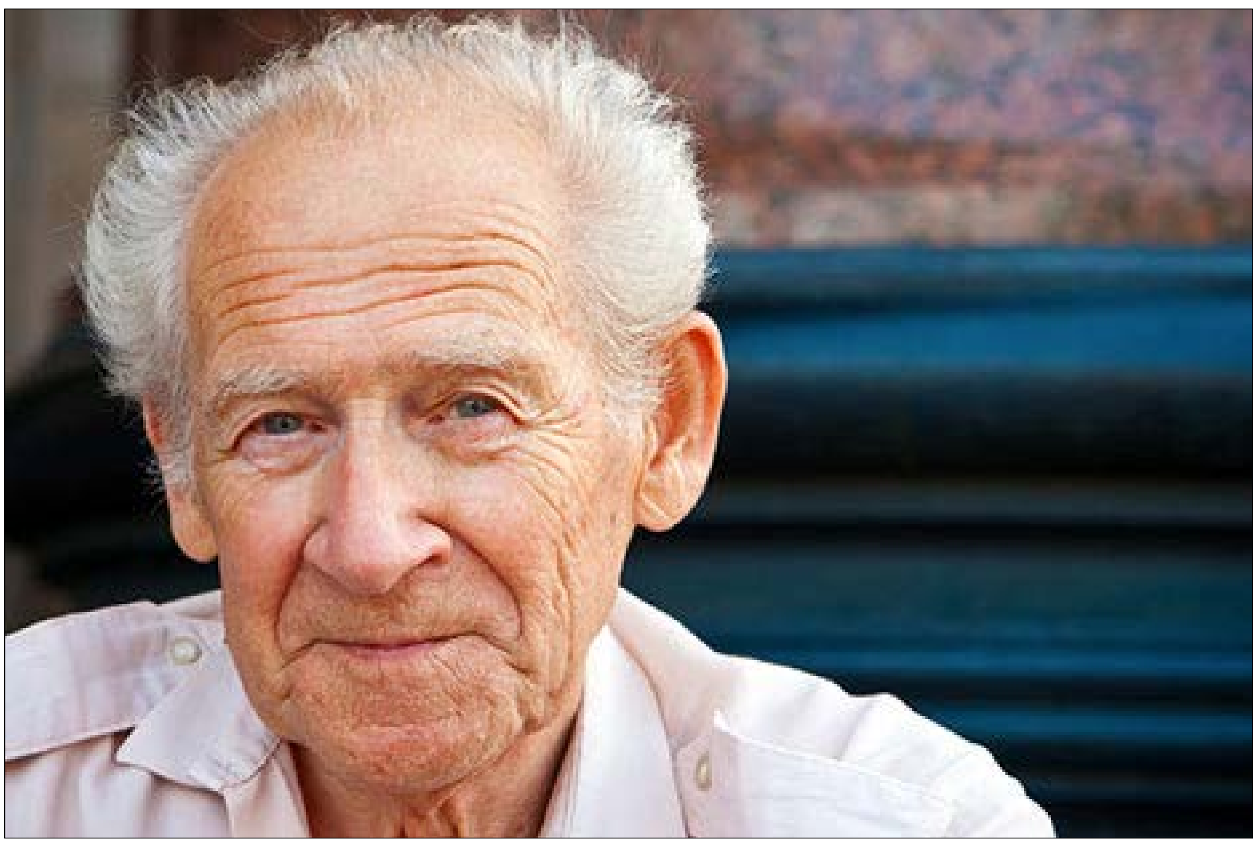
P.E.I. proposal could spark Canada Pension Plan reform

Robert L. Brown



In mid-September, the Minister of Finance for Prince Edward Island spoke to the Atlantic Provinces Economic Council (APEC) in Charlottetown. In his speech, he outlined the need for expansion of the Canada Pension Plan (CPP) and then described in some detail his idea for a "wedged" CPP expansion. This is not entirely new, as the idea arises from work done by Professor Michael Wolfson of the University of Ottawa (and previously of Statistics Canada). So the ideas have academic foundations — and now, new-found political support.

There are two serious issues that have held up any proposals to date for CPP expansion. First, it is difficult to mandate poor workers to contribute extra money to the CPP when any extra benefits would just be lost to clawbacks in their Guaranteed Income Supplement (GIS) benefits. In fact, given that there are several provincial income supplement plans, the loss of benefits could be a full $1 for every extra $1 of CPP benefit earned. So the lowest income earners would be forced to pay in money they really don't have to buy zero new net benefits. Not such a good deal.

The second important stumbling block is the fact that many research papers have found the workers truly in need in the next generation of retirees are those who earn between 50 percent of the average wage and 200 percent of the average wage — in today's dollar amounts, between $25,000 and

$100,000. Those below $25,000 do fairly well through combined Old Age Security (OAS), GIS and CPP benefits. Those earning over $100,000 appear to be able to take care of themselves with the tax incented vehicles now available.

That is why P.E.I. is proposing a new wedge benefit. Here is how it would work.

First, any new tier of benefits would be fully funded. That is, each generation of workers would pay in full for their own benefits. There would be no inter-generational transfers.

Today, the CPP provides an inflation protected defined benefit that replaces 25 percent of earnings up to approximately $50,000. Contributions are 9.9 percent of earnings or a maximum of about $4,600 (but split 50/50 with one's employer). Currently the maximum annual CPP benefit is about $1,000 a month or $12,000 a year. The average payment is about half of this or $500 per month.

The proposal would expand the CPP starting at earnings of $25,000. No new contributions or benefits would exist for those earning $25,000 a year or less. They would continue to depend on their OAS/GIS/CPP. Pensionable earnings would be expanded up to $100,000 and there would be a new tier of benefits equal to 15 percent of pensionable earnings for a total 40 percent benefit.

This could be paid for with new contributions of about 3.1 percent (shared 50/50 with one's employer — so 1.55 percent each), starting at $25,000.

Assuming a 40-year career, for someone earning $40,000, their contributions would increase by a total of $465 a year (split 50/50). This would bring an estimated increase in CPP benefits of $2,250 per year.

Someone earning $75,000 would pay extra contributions of $1,550 (split 50/50) and would see a $7,500 rise in pension benefits annually. The maximum increase in benefits would be $11,250 — almost double the current maximum benefit under the existing plan.

The P.E.I. proposal states these changes would be phased in over a relatively short period of time (two to three years). Further, Minister Sheridan argues the new contributions are not taxes because they are buying real benefits.

It is not easy to amend the CPP. It requires the approval of two thirds of the provinces with two thirds of the population of Canada (including Quebec). That is why previous reform proposals have failed.

The P.E.I. proposal now has the public backing of the Province of Ontario. Other provinces and the federal government are taking more cautionary stances worrying about new workplace costs in a shaky economy.

Clearly, this proposal is carefully thought out and deserves serious consideration. It is hoped that it will receive the very wide public review — and government consideration — it deserves.

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A version of this commentary appeared in *the Globe and Mail*, the Saskatoon *Star Phoenix* and *the Journal Pioneer*.

Health system costs not incurable but preventable

Aging population only small part of the problem

Michel Grignon

The tsunami metaphor is more and more often used in commentaries about the effect of aging on healthcare spending in Canada. It musters up images of devastation and irresistible strength submersing any levees the system might try to mount to oppose it. It is a powerful but misleading metaphor.

There is a worrying rise in healthcare spending in Canada, but it doesn't have much to do with population aging. To stay with the oceanographic metaphor, aging might be, at most, a modest tidal wave. The real tsunami of health spending is the result of changes in the way all patients are treated in the system, resulting from both price inflation (drugs and doctors cost more than ever) and technical progress (new diagnostic tests, surgeries and drugs).

The yearly increases in total healthcare spending in Canada — approximately $10 billion per year nowadays — does not result from aging per se, but the costs of treatment, including diagnostic tests, drugs and doctors, for all patients, young and old. It's not that we have too many seniors that will break the bank, but how those seniors, and others, are treated in the health system that affects the bottom line.

Put another way, aging on its own adds around $2 billion to the annual healthcare bill while changes in the cost of treatment per average patient adds $8 billion.

How is it possible? To answer, let's take a closer look at the age profile of healthcare spending: if age is on the horizontal axis and average spending per individual of a given age on the vertical axis, the profile resembles a valley. In other words, it costs a lot to be born, because it happens most often in a hospital; then, each year of age between one and 50 does not cost the health system much on average (the profile is flat and low) — but costs start picking up again at age 50 and the slope becomes steeper with age until plateauing around 80.

Contemplating such an age profile (drawn to illustrate a single year, say 2013), one might conclude that aging will increase spending dramatically. However, looking at two such annual profiles (one for 1993 and one for 2013), it is easy to see that the really striking change has been at the ground level: we spend much more today on anyone at any age than 20 years ago, and this is what really drives our healthcare costs.

This increase in costs for patient care has not been sudden, but has taken place over several decades and will likely continue apace. Costs have been driven by current investments in research and development (in industry and academia alike), insurance coverage for expensive, cutting edge treatments — whether truly beneficial or not — and our demand for longer and better quality lives.

We can't really do anything about costs resulting from our aging population, but we can make choices about what services we provide patients of all ages. These choices might mean rationing care (and, as a result, longevity and quality of life) but also, and preferably, making sure all patients receive essential care, but not unnecessary care. The latter is about reducing "waste" in our health system, interventions that have not been proven to enhance length or quality of life.

So, how do we distinguish necessary from unnecessary care?

We need to build our health system on evidence; we need to know how many years of life and how much quality of life we buy through the increased volume of services and the flow of new technologies in the healthcare system. We also need to pay for services and innovation on the basis of what they add to quality and quantity of life (outcome-based payments). Instead we continue paying for technology on the basis of how much it costs to develop, not how much it delivers.

It's time we stop throwing ever more money after the latest and greatest technologies in health services without knowing if we are getting a return on our investment. Our healthcare system suffers in the process.

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When more beds aren't enough

Alberta's new payment model for long-term care is a step in the right direction

TRAFFORD CRUMP AND ERIK HELLSTEN

Alberta's provincial health authority has recently come under fire by opposition party MLAs and activists alike for closing 77 Calgary long-term care beds damaged by the June floods. The angry reaction demonstrates the common misperception that a shortage of beds is the major cause of persistent waiting lists for long-term care.

Like other provincial governments, Alberta's has faced very public calls to build more long-term care beds for several years. Instead of bending to these expensive demands, Alberta is overhauling the long-term care system to try and use its existing beds better — a wise and financially prudent decision.

It's doing this by changing the way it pays long-term care homes, shifting to a new payment model called patient/care-based funding, or PCBF. PCBF provides more money to homes that care for sicker, more complex residents.

This is a sharp break with the past, where long-term care homes were given a flat rate based on historical trends and inflation. The old model ignored differences in health needs between residents. Consequently, homes had little reason to take more complex residents, who also tend to be the most costly to care for. Many of these individuals languished in hospital beds, waiting for long-term care placement, even though they no longer required the level of care hospitals provide.

If the Alberta government sticks to its guns and fully implements the new PCBF model, it should help reduce wait lists and improve financial accountability in long-term care.

Why is this the case? The reality is that wait lists for long-term care have less to do with the number of beds available and more to do with how these beds are filled. Long-term care homes are intended

to provide support to residents who require 24-hour nursing care, not to act as an alternative living facility for the elderly.

An example of this played out in Ontario in the early 2000s, when the provincial government funded the creation of more than 20,000 new long-term care beds. After a short-lived dip in wait times for long-term care, the waiting lists quickly returned. With residents funded at the same rate, many homes filled the new beds with those that were healthier and less complex — residents that could have been cared for just as effectively in less care-intensive settings, like assisted living.

Alberta's PCBF model reduces long-term care homes' financial incentive to cherry pick healthier residents by tying payments to the medical and physical needs of each resident. Payment rates for healthier residents are set at a lower level than those who are sicker. It also creates an incentive for homes to discharge healthier residents into less intense settings since the payments are lower. Healthier residents can be discharged into assisted living settings, for example, freeing up long-term care beds and reducing the need to build more beds.

Alberta isn't the first province to move in this direction. Stung by their costly experience in the early 2000s, Ontario began rolling out a similar patient-based funding model for long-term care homes several years ago. Now fully implemented, recent data suggest that the average complexity of residents being admitted to Ontario homes has indeed increased. Waiting lists have also decreased in the past two years.

PCBF also has risks that need to be watched carefully. In order to get their costs below the amount paid by PCBF, long-term care homes might skimp on services, potentially jeopardizing residents' safety or reducing their quality of life. Some might even try to alter residents' clinical data in order to make them seem more complex (and hence better-funded) than they really are — a process commonly known as "gaming." In the United States, this practice is considered fraud and offenders can go to prison.

Despite these pitfalls, Alberta's ambitious effort to match payments with the needs of residents is a step in the right direction — helping to reduce wait times and ensure the sickest patients get appropriate care. In the meantime, Alberta should resist popular pressures to adopt simplistic solutions like building new beds, which evidence shows does little by itself to solve the problem.

Other provinces with similar wait list issues will be watching from the sidelines to see if Alberta can maintain its course. Alberta has never been afraid to pioneer new methods in the past. In this instance, they should be applauded.

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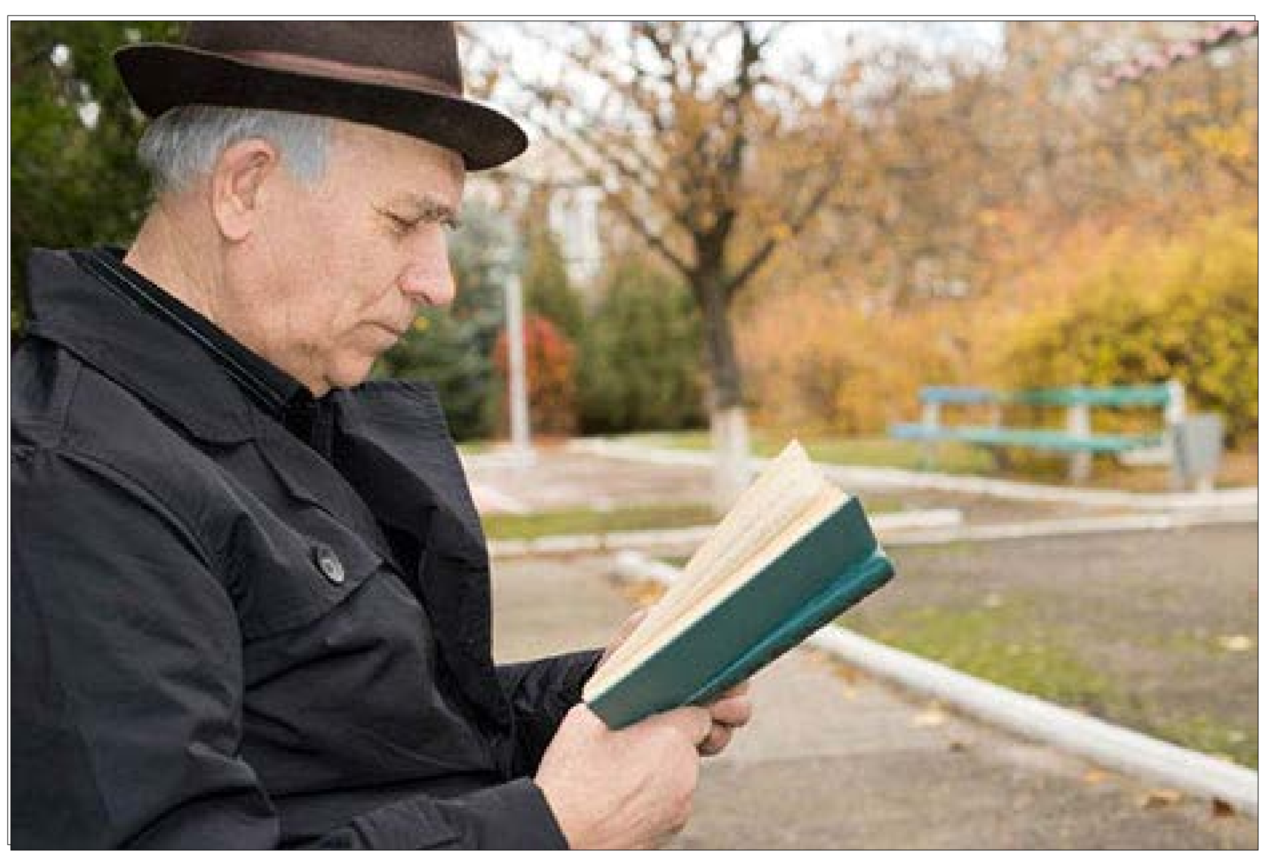
A version of this commentary appeared in *the Globe and Mail* and at HealthyDebate.ca.

An enhanced CPP would not come at the expense of the young

Why an expanded CPP is the right step forward

Robert L. Brown



Small and mid-size employers continue to walk away from sponsoring workplace pensions. Today less than 40 percent of private sector workers have any workplace pension at all and less than 20 percent have Defined Benefit pensions that experts agree are the best way to guarantee retirement income security.

Now, those very same employers, who are denying their workers pensions, are also arguing that workers should not have the right to achieve higher levels of retirement security through an expanded Canada Pension Plan (CPP). They are pitting younger workers against older workers and retirees by claiming that any expansion of the CPP today will benefit only the elderly — but that the funding of these new benefits will have to be met by younger Canadians in the form of increased contributions.

We are routinely told by ill-informed pundits that this is another example of those greedy geezers adding to their benefits and passing the bill to the next generation(s). It's a compelling spin, but it's not accurate.

If you are a "younger" Canadian, it is time to consider the truth of the matter.

Which world would you prefer? First: A world where employers increasingly provide no pension benefits whatsoever; where Canadians don't save enough for retirement income security; and even if your parents do save, their investment earnings will be low and, because they end up paying some of the highest management expense fees in the world, are virtually zero.

This is a world of two possible outcomes. One is that your parents will come to you and ask you to help support them in their retirement either by sharing food and shelter or by providing them with extra income to make ends meet. Or, the second possibility is that your parents and their entire generation will fall back onto Guaranteed Income Supplement (GIS), Canada's retirement income welfare system. They will do so at very high levels because the remaining baby boomer cohort is now moving into retirement and it will be younger Canadians picking up the tab; they will pay those GIS benefits through increased taxation (that is how GIS is financed).

Or, perhaps you'd rather a world where the CPP is moderately expanded today and where middle class Canadians can now (and in the future) retire at a level that guarantees they will not slip into poverty. If a CPP expansion were agreed upon today it would still take several years to implement. This period of time would include the required legislative and administrative changes, a notice period for Canadians, as well as a phase-in of the new contribution rates required to fund the expanded CPP. So, now is the time to act. Further delays cannot be supported.

Younger workers, when they retire, will also get these new improved larger benefits. The ultimate goal of any CPP enhancement would be to improve retirement income security for all Canadians.

For younger Canadians, another factor significantly protects your generation from paying increased contributions into the CPP if the system runs into sustainability problems. The CPP legislation contains an Automatic Balancing Mechanism (ABM). Under this ABM, if the current 9.9 percent contribution rate cannot sustain the CPP as it now stands, and if politicians cannot find a palatable solution to this financing issue, two things automatically happen. First, the indexation of benefits to the cost of living stops. This will bring pain that will be borne by the elderly. That is their share of the load. Second, contributions from workers (matched by their employers) would increase half-way to what would be needed to immediately provide and guarantee sustainability. That contribution increase would be the share to be borne by younger Canadian workers and their employers (50/50 split).

So, despite what you are being told, CPP expansion does not automatically mean that only the elderly benefit — all Canadians would be the recipients of an improved system. And if the CPP were to run into some problems of sustainability, it is not true that only the young suffer; the costs would be borne across generations.

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Chapter 7: Mental Health

Are our children stressed out?

Teaching self-regulation in the classroom reduces stress in kids, caregivers and teachers

Stuart Shanker

Childhood is changing and we'd better start to address it soon.

Ongoing research on kids' psychological development suggests that kids who are excessively with-drawn, or hyper-reactive, or act out too much are often sending a signal that their stress levels are too high. There is also a growing amount of research suggesting that kids have much higher levels of physiological stress than they did a generation ago, and the adults in their lives need to start rec-ognizing when children's problematic behaviours are due to these high stress levels.

Many perceive childhood as a time of simplicity and play. However, children show stress in complex ways that can represent serious signs of anxiety or a nervous system that is overloaded.

Understanding that burden requires us to think of child stress differently than adult stress. Kids don't have to deal with the pressures of work, money and marriage. So how can a five-year-old be stressed?

Noisy streets bustling with traffic in an increasingly urbanized society, or the incessant buzzing and flickering of a fluorescent bulb overhead or on a screen in front of them can contribute to our kids'

daily stress levels.

Using punishment and reward for kids who are overly disruptive and easily distracted doesn't work very well. In some cases, it even exacerbates the problem. Instead of trying to force children to behave according to the rules, we need to recognize these behaviours for what they are — signs of an over-stretched nervous system.

The Milton & Ethel Harris Research Initiative (MEHRI) at York University has developed an approach to improving childhood development based on tapping into kids' ability to manage their own stress. The process, called self-regulation, is being implemented in a number of B.C. school districts and will soon launch in Ontario schools and roll out in other jurisdictions across the country in stages.

In its simplest terms, self-regulation teaches kids to deal with being over-stressed by recognizing the signs and teaching them to reduce their physiological stress, gain control of their emotions, stay calm and alert. It refers to how efficiently and effectively a child deals with stress and then recovers.

This is critical because problems with self-regulation are a predictor of internalizing problems, anti-social behaviour and susceptibility to drug use later in life. Studies have also tied poor self-regulation to a wide range of issues, including obesity, risky behaviour and attentional problems.

The better kids self-regulate, the better they can control impulses or delay gratification and focus on learning.

And let's not forget about those who care for the child. Teaching successful self-regulation strategies to children can also lead to a dramatic drop in parental, caregiver and teacher stress, which in turn will benefit the child, too.

The first step is identifying stressors, whether physiological, emotional, environmental, cognitive or social. Perhaps a child needs a quiet library space at the back of the classroom to calm down or a learning space with fewer distractions.

If a child tends to wake up feeling irritable, exercises such as stretching, push-ups or star jumps and breathing exercises and yoga can improve their mood while teaching them control. But kids need to see these activities as fun. Making them the leaders of their own learning is a powerful tool that isn't used enough.

Play can also be a big part of this method. When kids lead playtime based on their interests, they become focused and tune into what their playmates are thinking as they decide what to build, what story to tell or what game to play. Play fosters connections between people, objects and ideas.

MEHRI's interest in self-regulation arose from their research into treatment options for autism, a condition that impairs social interaction, communication and leads to restricted, repetitive behaviour patterns.

A child with autism will often shut down under too much stress and become unable to engage with others. The MEHRI team of scientists and clinicians is exploring ways to mitigate the severity of the disorder by reducing the downstream effects of poor self-regulation, allowing for more self-control and social interaction.

Using these strategies at home and in the public school system means children with autism will have strategies to cope in different settings, even in classrooms full of potential distractions. The research also suggests that what works to reduce the stressors for children with autism can work for all chil-

dren. And that all children today do indeed need help with far too many stressors in their lives.

Our ability to reach as many kids as possible, teaching them the skills to manage their stress, can make all the difference in their future success.

Stuart Shanker is an expert adviser with EvidenceNetwork.ca, a distinguished research professor of philosophy and psychology, and director of the Milton and Ethel Harris Research Initiative at York University. He has recently published Calm, Alert and Learning: Classroom Strategies for Self-regulation *(Pearson) and helped launched the Canadian Self-Regulation Initiative in B.C. and Ontario. For more information go to www.self-regulation.ca.*

(December 2012)

A version of this commentary appeared in the *Winnipeg Free Press*, *the Vancouver Sun* and *the Huffington Post.*

How toxic stress is hurting our children

The subtle poison

NICOLE LETOURNEAU AND JUSTIN JOSCHKO

For most parents today, stress is a constant companion. Everyone's heard of the dangers of high blood pressure, of chronic workaholics having heart attacks at 40, of harried professionals pouring themselves an extra glass of wine (or three) with dinner. Pausing at our desks or kitchen tables for an all-too-brief moment, many of us long for the carefree days of childhood, when our lives seemed simple and our worries small and far away.

However, childhood is not quite the stress-free paradise that our rose-tinted memories might suggest. Children — even infants — can suffer from chronic, toxic stress. It's stress of a very different sort than that of meetings and mortgage payments, but its long-term effects can be no less serious.

Last year, the American Academy of Pediatrics launched an urgent call to action informing health-care practitioners of the dangers of toxic stress to children, and Harvard University established the Centre on the Developing Child to study its effects. Cleary, toxic stress is serious stuff.

But what is it, exactly?

Even before they can stand on their own, children have already mastered a balancing act of sorts.

It's a balance not of posture, but of hormones and chemicals meticulously regulated to keep us in a state of internal harmony called "homeostasis."

Homeostasis is where our bodies function best. Everything from heart rate to digestion to internal temperature runs smoothly. In the face of stress, our body shifts gears. Stress hormones flood our bloodstream, initiating a red alert status commonly called fight or flight. Our hearts pound, our digestive and immune systems hibernate, and homeostasis takes a back seat to survival.

Once the source of anxiety passes, our bodies downshift to homeostasis and things get back to normal. This "gear change" was a vital survival strategy for our distant ancestors, when a burst of adrenaline could mean the difference between being quick and being dinner.

However, in a modern society, stress doesn't come in short bursts. It comes in constant, rolling waves that our bodies aren't built to handle. As a result, our stress response systems sometimes get overloaded, and our bodies stop returning to homeostasis. Our gears stop shifting quite so smoothly. They may even jam up altogether. The result: toxic stress.

This is bad enough in adults. In children, it can be a disaster.

Children's young bodies and minds, still adjusting to the business of achieving homeostasis, can become dangerously and permanently misaligned by toxic stress. Researchers have linked toxic stress in childhood to an increased risk of depression, addiction, teen pregnancy, alcoholism, liver disease and heart problems, among other ailments.

However, the last thing we all need is one more thing to stress about. So here's the good news: children can actually handle quite a lot of stress. From everyday frustrations — pinching their fingers in a cupboard, getting a booster shot or dropping an ice cream cone on the floor — to more serious, traumatic events — a broken leg, the death of a grandparent or a divorce — children can bounce back, as long as they have one important thing: a nurturing, supportive caregiver.

The really toxic part of "toxic stress" isn't the stress at all. It's stress without a supportive caregiver present to mitigate it.

Stress regulation is a complicated process involving many different parts of the brain, and young children aren't able to manage it all on their own. They need an adult caregiver to help them calibrate the way they respond to stress. It doesn't take much: regular hugs, smiles and gentle encouragement do the trick. When parents are abusive or negligent or simply not around enough, their children miss out on this critical step.

Children growing up in low income households may be subject to disproportionate amounts of toxic stress that their parents may be largely unable to control: inadequate nutrition, inappropriate housing conditions, an inability to afford prescription drugs, dental care or other health services can make toxic stress a real and present danger. Policies that support early childhood education, income assistance and affordable housing can provide the touchstone struggling children — and their parents — need to thrive.

We must make sure that no child in Canada grows up in an environment of toxic stress. We need to work together to provide families with the support they need to support their children in turn.

Nicole Letourneau is an expert adviser with EvidenceNetwork.ca and a professor in the Faculties of Nursing and Medicine. She also holds the Norlien/Alberta Children's Hospital Foundation Chair in Parent-Infant Mental Health at the University of Calgary.

Justin Joschko is a freelance writer currently residing in Ottawa. Their co-authored book, Scientific Parenting*, is due for release in August.*

(April 2013)

A version of this commentary appeared in *the Huffington Post*, the *Winnipeg Free Press* and *the Waterloo Region Record.*

Les effets nocifs du stress toxique sur nos enfants

Un poison subtil

NICOLE LETOURNEAU ET JUSTIN JOSCHKO

Chez la plupart des parents d'aujourd'hui, le stress est un compagnon constant. Nous avons tous entendu parler des dangers qu'entraîne une tension artérielle élevé, des bourreaux de travail qui font une crise cardiaque à quarante ans, des professionnels débordés qui se versent un autre verre de vin au souper (ou un troisième). Appuyés sur notre bureau ou notre table de cuisine pendant un infime moment, nombre d'entre nous rêvons de notre enfance et de l'époque où nous étions sans souci et libres de toutes inquiétudes.

Toutefois, l'enfance n'est pas tout à fait le paradis sans stress que suggère notre mémoire, qui peut idéaliser cette période de vie. Les enfants, même les nourrissons, peuvent souffrir d'un stress chronique et toxique. C'est un stress qui est très différent de celui associé aux réunions et aux paiements d'hypothèque, mais les effets à long terme n'en sont pas moins importants.

L'an dernier, l'American Academy of Pediatrics [Académie américaine de pédiatrie] a lancé un pressant appel à l'action, informant les professionnels de la santé des dangers du stress toxique chez les enfants. En fait, l'Université Harvard a mis sur pied le Centre on the Developing Child [Centre sur le développement de l'enfant] pour étudier ses effets. De toute évidence, le stress toxique est un grave

problème.

Mais en fait, qu'est-ce que c'est?

Avant même de se tenir debout tout seuls, les enfants ont déjà maîtrisé une forme d'équilibre. Il ne s'agit pas d'un équilibre lié à la posture mais plutôt d'un équilibre hormonal et chimique, un processus de régulation méticuleux qui nous assure une harmonie interne appelée l'« homéostase ».

L'homéostase se produit lorsque notre corps fonctionne de façon optimale. Tout roule bien, de la fréquence cardiaque à la digestion et la température interne. Dans un contexte de stress, notre corps change de vitesse. Des hormones du stress s'introduisent massivement dans le sang, initiant un état d'alerte aigu communément appelé la réaction de lutte ou de fuite. Notre cœur bat plus fort, nos systèmes digestifs et immunitaires entrent en état d'hivernation, et la survie prend le dessus sur l'homéostase.

Une fois la source d'anxiété passée, notre corps passe à une vitesse inférieure et retrouve un état normal d'homéostase. Ce « changement de vitesse » constituait une stratégie essentielle chez nos lointains ancêtres, puisque leur survie dépendait de cette poussée d'adrénaline, qui les rendait rapides et leur évitait d'être dévorés.

Par ailleurs, dans une société moderne, le stress n'est pas bref et intense mais plutôt constant, comme des vagues qui déferlent. Or nos corps ne sont pas équipés pour gérer ce type de stress. Par conséquent, notre système de réaction au stress est parfois surchargé et notre corps cesse de revenir à l'état d'homéostase. Nous ne passons plus d'une vitesse à l'autre de façon harmonieuse et le tout peut même s'enrayer, ce qui risque d'entraîner un stress toxique.

Cet état est assez pénible chez les adultes, mais chez les enfants, il peut s'avérer catastrophique.

Chez les enfants, le corps et les fonctions cérébrales sont encore à s'ajuster pour atteindre l'homéostase et le stress toxique peuvent leur causer de dangereux déséquilibres permanents. Les chercheurs ont établi chez les enfants des liens entre ce stress et, entre autres troubles, un risque accru de dépression, de toxicomanie, de grossesse au stade de l'adolescence, d'alcoolisme, de maladies du foie et de problèmes cardiaques.

Mais la dernière chose dont nous avons besoin, c'est d'une autre raison pour stresser. Donc, la bonne nouvelle, c'est que les enfants peuvent en fait gérer une grande quantité de stress. Des petites frustrations quotidiennes — se coincer un doigt dans la porte de l'armoire, recevoir un vaccin de rappel ou échapper son cornet de crème glacée sur le plancher — à des événements plus graves et traumatisants — une jambe cassée, le décès d'un grand-parent ou un divorce — les enfants peuvent rebondir, à condition d'avoir une chose importante : une personne aimante et soutenante qui prend soin d'eux.

La partie vraiment toxique de ce type de stress, ce n'est pas le stress même, c'est l'absence d'une personne soutenante qui prend soin de l'enfant et atténue le stress.

La régulation du stress est un processus compliqué auquel participent de nombreuses parties du cerveau, et les jeunes enfants sont incapables de gérer tout cela uniquement de leurs propres efforts. Ils ont besoin d'un adulte proche qui les aide à calibrer leur réaction au stress. Il suffit de peu : des câlins, des sourires et un encouragement bienveillant offerts régulièrement suffisent. Les enfants de parents violents, négligents ou peu présents passent à côté de ce stade important.

Les enfants qui grandissent dans des foyers à faible revenu peuvent vivre un taux de stress dispro-

portionné, que leurs parents peuvent difficilement contrôler. Une nutrition et des conditions de logement inadéquates ou un manque de ressources financières pour acheter des médicaments d'ordonnance, bénéficier de soins dentaires ou autres services de santé peuvent transformer le stress toxique en un danger bien réel et présent. Des politiques qui favorisent une éducation dans la petite enfance, une aide au revenu et des logements à prix abordables peuvent jouer un rôle clé dans les efforts pour offrir aux enfants défavorisés, ainsi qu'à leurs parents, des conditions de vie épanouissantes.

Nous devons veiller à ce qu'aucun enfant canadien ne grandisse dans des conditions de stress toxique et nous devons travailler conjointement pour offrir aux familles le soutien dont elles ont besoin pour qu'elles puissent à leur tour prendre soins de leurs enfants.

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A parent-first approach helps children

Why pre-natal care and family-focused policies are good for everyone

NICOLE LETOURNEAU AND JUSTIN JOSCHKO

Our social safety net has a broken thread, and the ones who slip through the resulting hole are often the smallest among us: our children.

On every metric, children from disadvantaged homes face greater challenges to success than their more privileged peers. As a result, they do worse in school, get poorer paying jobs and suffer disproportionately from violence, addiction and mental health issues.

Policy-makers have tried to remedy this problem in dozens of ways — through our primary schools and our focus on early childhood education, to name a few. But are these programs enough? Research shows us that the period in children's lives most critical to their success occurs long before school, or even daycare. Indeed, it occurs before the child is even born.

Environmental influences begin to shape children from the moment of conception. As the fertilized egg divides, creating zygote, embryo, and fetus, the infant-to-be derives far more from her mother than simple nutrition. She also receives a veritable cocktail of hormones and other chemicals that can have a profound, lifelong impact on her mental and physical growth.

The most infamous examples of this would be fetal alcohol syndrome and the low birth weights associated with smoking while pregnant. But poor nutrition, prescription medicine, environmental pollutants and even stress can have just as serious an effect.

The connection between prenatal stress and postnatal disease has been carefully studied in rats and rhesus monkeys, and linked to everything from hormone imbalances to schizophrenia to heart disease. Humans are harder to study for ethical reasons, but sometimes history conducts a study for you.

Such an event occurred in the Netherlands during the winter of 1944, when a Nazi food embargo caused one of the most devastating famines in Europe's recent history. Mothers who were pregnant during the height of the famine gave birth to children with a substantially greater risk of obesity, heart disease, diabetes and schizophrenia. The emotional and physical stress of the famine had a tangible impact not just on their children, but their children's children, creating a cycle of disease that continues to this day.

Generational cycles of disease happen in Canada, too. The environment continues to exert a tremendous influence through infancy and early childhood, and the many stresses of life in a financially struggling family trickle down to them. The result: underprivileged kids suffering disproportionately from obesity, depression and ADHD, and growing into adults with greater risks of alcoholism, behavioural disorders and even certain cancers.

The solution is not just more support for children, but more support for families.

Reduce the stress in their lives and we put their children on an even footing. From there, a network of postnatal resources could provide struggling mothers with the support they need to support their children. Even simple gestures, such as providing new mothers with books to read to their children, are showing promise for improving literacy.

Canadians value fairness. We are a society made up mostly of immigrants, individuals from every corner of the globe who came here to make a better life for themselves. A nation of fresh starts, where success favours brains over birthrights. Or at least we strive to be.

Our country isn't perfect — no country is — but equality is certainly part of our national bedrock, the foundation on which many of our social programs, from universal healthcare to employment insurance, rest.

But inequality goes deeper than kindergarten classes. To help children, we need to help parents, beginning before birth. If we don't, everyone suffers. A country that ignores its youth is a country with fewer taxpayers, a greater burden on social programs and more crime.

A parent-first approach isn't just the right choice; it's the smart choice.

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Une approche d’abord axée sur les parents aide les enfants

Pourquoi des soins prénataux et des politiques axées sur la famille sont une bonne chose pour tous

NICOLE LETOURNEAU ET JUSTIN JOSCHKO

Il y a une déchirure dans les mailles de notre filet social et les victimes du trou causé par cette déchirure sont généralement les plus petits d’entre nous : nos enfants.

Selon tous les indicateurs, les enfants provenant de familles défavorisées doivent surmonter pour réussir dans la vie des difficultés plus grandes que ceux des familles plus favorisées. Il en résulte que ces enfants obtiennent de moins bons résultats à l’école, accèdent à des emplois moins rémunérateurs et sont aux prises dans une plus grande proportion avec des problèmes de violence, de dépendance et de santé mentale.

Les décideurs ont tenté de remédier à cette situation de multiples façons, à l’aide par exemple de programmes mis en place dans les écoles primaires ou en mettant l’accent sur l’éducation de la petite enfance, pour ne nommer que quelques-unes des mesures prises. Mais ces programmes suffisent-ils? Les recherches ont démontré que la période la plus cruciale dans la vie d’un enfant en ce qui concerne ses chances de réussite se situe bien avant l’âge scolaire, et même avant l’âge de la garderie.

En fait, elle se situe avant la naissance de l'enfant.

Il y a en effet influence du milieu sur le développement de l'enfant dès le moment de sa conception. Pendant la division de l'ovule fécondée, la création du zygote, l'apparition de l'embryon et la formation du fœtus, l'enfant en devenir reçoit déjà de sa mère beaucoup plus que de simples éléments nutritifs. Il reçoit un véritable cocktail d'hormones et d'autres substances biochimiques pouvant avoir un impact profond et permanent sur son développement mental et physique.

Les exemples les plus tristement célèbres de ce type d'impact sont sans nul doute le syndrome d'alcoolisation fœtale et l'insuffisance de poids à la naissance associée à l'usage du tabac pendant la grossesse. Toutefois, une mauvaise alimentation, la consommation de médicaments sur ordonnance, l'exposition à des polluants environnementaux et même le stress peuvent avoir des effets tout aussi graves.

Des chercheurs ayant étudié attentivement les liens entre le stress prénatal et les maladies postnatales chez les rats et les macaques rhésus sont arrivés à relier le stress prénatal à toutes les formes d'affections qu'ils ont étudiées, du déséquilibre hormonal à la schizophrénie en passant par les maladies du cœur. Il est évidemment plus difficile d'étudier l'être humain pour des raisons éthiques, mais il arrive parfois que des événements historiques puissent avoir valeur d'étude scientifique.

Un tel événement s'est produit aux Pays-Bas pendant l'hiver 1944, alors qu'un embargo nazi sur les denrées alimentaires a provoqué l'une des famines les plus dévastatrices de l'histoire récente de l'Europe. Les mères qui étaient enceintes durant la période où la famine a frappé le plus fort ont donné naissance à des enfants qui présentaient un risque beaucoup plus élevé que la normale d'obésité, de maladie du cœur, de diabète et de schizophrénie. En outre, le stress émotionnel et physique provoqué par la famine a eu un impact observable non seulement chez les enfants de ces femmes, mais également chez les enfants de leurs enfants, déclenchant ainsi un cycle de maladies qui perdure encore aujourd'hui.

De tels cycles de maladies se poursuivant d'une génération à l'autre sont également présents au Canada. Dans la mesure où le milieu continue d'exercer une énorme influence pendant la première enfance et la petite enfance, les nombreux stress que peut occasionner la vie quotidienne au sein d'une famille ayant des difficultés financières se répercutent assurément sur les jeunes enfants. Le résultat est le suivant : les enfants provenant de milieux défavorisés souffrent en plus grande proportion d'obésité, de dépression et de troubles d'hyperactivité avec déficit de l'attention, et une fois adultes ils présentent un risque accru d'alcoolisme, de troubles du comportement et même de certains cancers.

La solution n'est donc pas simplement d'accroître le soutien aux enfants, mais bien d'accroître également le soutien aux familles.

En réduisant le niveau de stress des familles défavorisées, nous donnons aux enfants de ces familles les mêmes chances de réussite que les autres. À partir de là, un réseau de ressources postnatales pourrait offrir aux mères en difficulté l'aide dont elles ont besoin pour soutenir leurs enfants. Même les gestes les plus simples, comme donner aux nouvelles mères des livres à lire à leurs enfants, sont porteurs de la promesse d'un meilleur taux d'alphabétisme.

L'égalité est une valeur importante pour les Canadiennes et les Canadiens. Nous formons une société composée en grande partie d'immigrants, de personnes venues des quatre coins du monde pour se faire une vie meilleure. Notre pays est une terre propice aux nouveaux départs, où les capacités

intellectuelles ont plus de valeur que les privilèges de la naissance. Du moins, nous nous efforçons de faire du Canada un tel endroit.

Notre pays n'est évidemment pas parfait (aucun pays ne l'est), mais l'égalité fait certainement partie des fondements de notre nation, il s'agit de la pierre d'assise sur laquelle reposent nombre de nos programmes sociaux, qu'il s'agisse de notre système de soins de santé universel ou de notre régime d'assurance-emploi.

Les inégalités sont toutefois un problème dont l'origine est beaucoup plus profonde que la classe de maternelle ou la garderie. Pour aider les enfants, nous devons aider les parents, avant même la naissance. En l'absence d'une telle aide, c'est la société entière qui en souffre. Un pays qui ignore sa jeunesse est un pays où il y a moins de contribuables, où les programmes sociaux sont grevés d'un plus lourd fardeau et où le taux de criminalité est plus élevé.

Adopter une approche d'abord axée sur les parents, ce n'est donc pas seulement un bon choix, c'est également un choix intelligent.

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Chapter 8: Obesity

Why having weight loss as a New Year’s resolution may be bad for your health

JENNIFER L. KUK

Every year, many Canadians will pledge to start the year off by losing some weight to get healthier. There is plenty of evidence to show that losing weight can improve your blood pressure, blood sugar and even your cholesterol rates. However, losing weight and being healthy are not the same thing.

You can get healthier without losing weight, and for some, losing weight may actually be bad for your health.

When an individual loses weight, they will lose fat mass, but some of that weight loss comes from muscle mass. Muscle mass burns many more calories than fat, and accounts for a large proportion of the energy we burn, even at rest. In other words, loss of muscle mass may be counterproductive to long-term weight loss goals.

Also, when an individual loses weight, their body will try to protect the body weight by decreasing the number of calories the body burns (a change in “metabolic rate”). These two factors help to explain why so many of us may find it difficult to continue to lose weight after a while, and why over 90 percent of individuals who lose weight will regain that weight within a few years.

If that isn't bad enough, there is evidence to suggest that individuals who try to lose weight and repeatedly fail will have greater weight gain over time than individuals who do not try to lose weight at all. This weight cycling or yo-yo dieting has also been linked to higher rates of diabetes, cardiovascular disease, cancer and higher death rates. Reasons for this are still unclear, but research suggests that unless you can keep the weight off, dieting may have negative effects on your health.

Why is it so difficult to maintain weight loss over the long term?

One of the reasons is that many individuals approach weight loss as a quick fix. Done correctly, weight loss should be a lifelong process and not a short term goal. For example, after losing the weight, an individual cannot return to the lifestyle that led them to their elevated weight in the first place since this would only lead them back to their original weight — or higher.

Those who struggle with their weight need to explore underlying causes first, which will help to explain the reasons for their struggle. Factors that may contribute to weight gain include certain medication use, exposure to environmental pollutants, too much ambient light exposure or sleep deprivation. But even stressing about your weight can trigger cravings for high fat and high sugar foods and exacerbate weight gain.

There is some good news, however.

There is actually a subset of the population who appear to be perfectly healthy despite an elevated body weight. Research is undecided about the long-term health consequences for these individuals, but it has been suggested that weight loss may not benefit their health. In fact, one important study shows that weight loss may make their health worse.

So, thinking of losing weight in the New Year?

Consider first why you want to lose weight and whether or not you have the right approach. All weight loss methods require time, effort and/or money and the health benefits aren't guaranteed even if you are successful in achieving your weight loss goals. So what should you do?

Here's what the research to date tells us. If you want to start the new year off by getting healthier, get active, eat better, try not to gain any more weight and don't stress about the small stuff. If you want to lose weight, try something that you can sustain for the rest of your life — and remember that slow and steady wins the race.

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(December 2012)

A version of this commentary appeared in the *Winnipeg Free Press*, the Vancouver *Province* and *the Waterloo Region Record*.

Obesity epidemic threatens the sustainability of our work-force and our healthcare system — but it doesn't have to

ARYA M. SHARMA

There's a common catch phrase used by those championing efforts to prevent childhood obesity: "This may be the first generation of kids to not outlive their parents." Sounds terrifying — except that so far, there is little evidence to support this idea.

Over the past several decades we have seen a remarkable increase in adult and childhood obesity, yet life expectancy has continued to increase and may well continue to do so.

This is not to say that obesity is not a major driver of health risks. Obese individuals are far more likely to develop diabetes, heart disease, arthritis, sleep apnea and even breast cancer. But survival of individuals with these conditions continues to increase. In fact, never have so many with these conditions lived to a "ripe old age."

This "success" poses important challenges to our healthcare system. No doubt obesity will drive some health conditions, but rather than translating into premature deaths, it is far more likely that today's kids will live even longer — and live longer with chronic diseases — than their parents.

Thus, the obesity epidemic's real burden is an unprecedented increase in "chronic diseases of the

young." This has implications for both our workforce and for our healthcare system.

For the workforce, this means that more employees will be living with obesity and the resulting increase in diabetes, hypertension, sleep apnea, arthritis and other chronic health conditions. While these conditions can be managed, the resources and the delivery of healthcare cannot remain the same as it is today for the "chronic diseases of the elderly."

While the retiring baby boomers with these conditions can perhaps afford to sit around in waiting rooms for their clinic appointments, younger workers will be unable to leave their workplace as often as would be required for the management of their conditions. Indeed, success of managing chronic conditions is directly related to the number of visits with a health professional — the more frequent and regular these visits, the better the condition tends to be controlled.

So our healthcare system will need to develop and adapt to providing regular visits to a large proportion of the workforce, which can ill afford to take time off for lengthy daytime consultations.

There are essentially three ways to deal with this challenge, all of which must be considered: We need to open community chronic care clinics after hours; we need to relocate chronic care clinics to the workplace; and we need to use technology to deliver disease management programs to employees.

It is unlikely that the first option will acceptable to most health professionals. A far better approach would be to relocate chronic care clinics to our places of employment, making it possible for employees to consult with a health professional during the course of their work day. It is not the length but the frequency of such encounters that matter. Simply stepping on a scale, having your blood pressure taken or your glucose levels checked with a quick word of encouragement from a health professional is often enough to keep patients on track, and does not require a lengthy visit to the doctor's office.

Finally, electronic communication including telehealth consultations that employees can participate in from their desk computer or hand-held devices could replace frequent and expensive in-person visits to a health professional.

The sooner our governments and employers prepare for this obesity driven epidemic of "chronic diseases of the young," the more likely we will be able to avoid the expensive complications of these conditions — and save our healthcare system in the process.

This should, of course, not distract from obesity prevention efforts, but even the most optimistic forecasts do not foresee any significant reduction in the number of Canadians living with obesity and related health problems at least well into the middle of this century.

Not preparing for the expected consequences of the obesity epidemic will surely burden the healthcare system and negatively impact the productivity of our workforce. All of this can be avoided by changing how we deliver healthcare — taking chronic disease management directly to the community — and providing care at the workplace.

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A version of this commentary appeared in *the Toronto Star*, *iPolitics.ca* and *the Hill Times*.

Une épidémie d’obésité menace la santé de la population active et la durabilité de notre système de santé, mais il y a des solutions.

Arya M. Sharma

Les porte-paroles de la prévention de l’obésité chez les enfants ont recours à une phrase bien connue : « La génération actuelle d’enfants sera peut-être la première à mourir plus jeune que la génération antérieure. » Bien que terrifiante, cette affirmation ne repose pas sur des données probantes.

Au cours des dernières décennies, nous avons été témoin d’une hausse importante du taux d’obésité chez les adultes et les enfants. Par ailleurs, l’espérance de vie des personnes obèses continue d’augmenter et la tendance semble se maintenir.

Cela dit, l’obésité demeure toujours un important facteur de risque pour la santé. Les personnes obèses sont beaucoup plus à risque de souffrir de diabète, de maladie du cœur, d’arthrite, d’apnée du sommeil et même de cancer du sein. Mais l’espérance de vie malgré ces maladies continue de croître et les gens qui en souffrent n’ont jamais été aussi nombreux à vivre aussi vieux.

Cette « victoire » entraîne des défis de taille pour notre système de santé. Il n’existe aucun doute à l’effet que l’obésité augmente les risques de certaines maladies. Mais loin d’être menacés d’un décès

prématuré, les enfants d'aujourd'hui vivront probablement plus longtemps que leurs parents, malgré les maladies chroniques qui les affligeront.

En fait, le réel fardeau qu'entraîne l'épidémie d'obésité réside dans une augmentation sans précédent des « maladies chroniques chez les jeunes » et dans les conséquences qui en découlent, tant pour la population active que pour notre système de santé.

Pour la population active, cela signifie qu'un plus grand nombre de travailleurs souffriront d'obésité et de ses effets : diabète, hypertension, apnée du sommeil, arthrite et autres maladies chroniques. Bien que ces maladies soient gérables, les ressources et la prestation de soins prévues présentement pour soigner « les maladies chroniques des aînés » ne pourront être les mêmes dans l'avenir.

Les baby boomers retraités atteints de telles maladies peuvent peut-être se permettre de patienter dans les salles d'attente pour voir leur médecin mais les jeunes travailleurs ne pourrons pas quitter leur lieu de travail aussi souvent que la gestion de leurs maladies l'exigera. En effet, la fréquence des visites chez un professionnel de la santé est la clé d'une gestion efficace des maladies chroniques. Plus les visites sont nombreuses et régulières, plus les maladies sont maîtrisées.

Les services de santé devront donc être élargis et adaptés de façon à offrir des traitements médicaux réguliers à une grande part de la population active, laquelle ne peut prendre congé pour attendre dans les salles d'attente pendant les heures de travail.

Nous devons considérer essentiellement trois façons de relever ces défis : mettre sur pied des cliniques communautaires spécialisées en maladies chroniques qui offrent des services après les heures de travail; relocaliser les cliniques spécialisées en maladies chroniques sur les lieux de travail; et utiliser la technologie pour mettre en œuvre des programmes de gestion de maladies à l'intention des travailleurs.

La plupart des professionnels de la santé considéreront probablement la première option comme inacceptable. L'approche qui préconise la relocalisation des cliniques de soins de maladies chroniques sur les lieux de travail est beaucoup plus intéressante, puisqu'elle permettrait aux travailleurs de consulter un professionnel de la santé pendant les heures de travail. Ce n'est pas la durée mais plutôt la fréquence des consultations qui importe. Le contrôle du poids à l'aide d'un pèse-personne et la prise de la tension artérielle et du taux de glucose, ainsi qu'un mot d'encouragement de la part d'un professionnel de la santé constituent des moyens efficaces pour maintenir les gens en bonne santé et leur éviter de passer des heures dans la salle d'attente d'un médecin.

Enfin, des communications électroniques, y compris des consultations télésanté auxquelles les employés peuvent participer au moyen de l'ordinateur de leur poste de travail ou d'un appareil portable, peuvent remplacer de fréquentes et coûteuses visites chez un professionnel de la santé.

Plus vite nos gouvernements et nos employeurs se prépareront pour cette épidémie de « maladies chroniques chez les jeunes » liées à l'obésité, plus nous serons en mesure d'éviter les complications coûteuses de ces maladies et de maintenir en place notre système de santé.

Évidemment, cette démarche n'exclut pas les efforts de prévention de l'obésité, mais même les prévisions les plus optimistes n'anticipent pas une diminution significative de l'obésité chez les Canadiens et des problèmes de santé qui accompagnent cet état, du moins pas avant le milieu du siècle en cours.

Une absence de préparation pour contrer les conséquences qui découleront de l'épidémie d'obésité

entraînera assurément un fardeau pour notre système de santé et des effets négatifs sur la population active. Tout cela peut être évité en modifiant l'approche de prestation de soins, notamment en réacheminant la gestion des maladies chroniques au sein même de la collectivité et en offrant des soins sur les lieux de travail.

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Playing violin for your health

Lifestyle changes work when you choose something you love

ARYA M. SHARMA

Now that we've kicked off a new year, not a day passes without some news outlet asking me for tips on healthy living. What do I need to eat more (or less) of? What type of exercise is best and how many minutes a day do I need?

My answer generally comes down to asking a simple question in return: Would you really want to give up something you enjoy? Or, even less likely, do you really want to start doing something you don't do?

Let us assume that there is now conclusive evidence that playing just 20 minutes of violin a day substantially reduces your risk of cancer, diabetes, heart disease, stroke, Alzheimer's and even male-pattern baldness.

Based on these finding, Health Canada launches a major initiative proclaiming the benefits of violin playing for health.

There is now a whole industry of personal violin trainers, and you can sign up for violin sessions at your local YMCA (which has thrown out the exercise machines to make more room for the violin

enthusiasts). Magazines and bloggers opine on whether it matters what music you play on your instrument and proffer expert advice on the best instruments and latest accessories.

There is a lively debate on whether playing the fiddle or viola has the same health benefits as the violin. Can it, perhaps, be any string instrument played with a bow? Does it matter whether the bow has real horsehair or the strings are catgut?

Does it matter whether you play for expression or speed? Alone or with friends? And why just 20 minutes? Wouldn't 40 minutes or perhaps even a couple of hours a day make you even healthier? How about signing up for a stringathon?

At your next annual physical, your doctor asks, "And how many minutes of violin do you get in every day?" If you admit you don't, here's a copy of Canada's Violin Guide extolling the many health benefits of violin practice.

And once you play regularly, you may even experience the violinist's high. You will be on the perfect path to violin addiction!

But now imagine that you happen to be someone who simply hates violin.

You have no sense of tone or rhythm, the very thought of picking up the instrument (any instrument) makes you want to stay in bed. Perhaps memories of the hated violin teacher ruined it for you in grade school. Perhaps you were the one always picked last for the class ensemble.

The people who love their violin do not understand. Why are you choosing not to play when everything points to the benefits? And it is just 20 minutes, is that too much to expect?

Interestingly enough, it turns out that you are by no means in the minority. According to the latest Canadian Community Health Survey, 95 percent of Canadians fail to achieve even the minimum 100 minutes of recommended weekly violin.

It is not that most Canadians do not like the violin. They do love listening to and watching violin concerts, they just don't like playing it themselves. In fact, over the past years several new violin channels have popped up on TV. There are now national and international violin competitions.

And yet, most people will simply refuse to pick up the violin. This, despite the tax credits offered to violin players. Do we really have to discuss taxes and higher health premiums for non-players?

Why are these people digging their own graves by simply refusing to pick up the violin? Don't these people get it?

Well, they get it alright. They simply don't enjoy the violin — no matter the health benefits.

Violins aside, here's the bottom line: If you want to improve your health this New Year, make sure you take up something you love to do. If you choose something you despise, you'll only last a few weeks at most. For healthy habits to stick, they have to be in place for the long-term, regular — and fun (or at least, not unpleasant).

Choose small, attainable goals, regular habits that you'll enjoy completing. It might mean a 20 minute daily walk or an increase in delicious whole foods over processed foods. It might mean joining a team sport or making the time for more home cooked meals.

But it should always be something you enjoy doing, and something that you can probably stick with for a lifetime.

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A version of this commentary appeared in *the Huffington Post*, *the Hamilton Spectator* and *the Guelph Mercury*.

It’s time for government action on obesity

Regulating the food and beverage industry a good place to start

JOHN MILLAR

You’ve heard it already: obesity is epidemic in Canada and is contributing to an increased prevalence of hypertension, diabetes, heart disease, stroke, cancer and other chronic conditions. What you don’t often hear is that as a result, healthcare costs keep rising, posing a threat to the sustainability of our publicly funded healthcare system. The obesity epidemic also compromises our workforce productivity and reduces economic competitiveness.

In the face of this burning issue, there has been little government response.

Although at the most basic level, obesity is the result of an excess of calories consumed over calories expended, the causes and solutions are highly complex, involving everything from stress levels to social equality to food production and urban design, and a cluster of other complex issues. But this complexity must not continue to be a reason to do nothing.

There is sufficient evidence to guide governmental action — now.

So, where to start? Reducing calorie consumption is the highest priority. While physical activity is important for health, research suggests that by itself it is not effective for weight control and so it is not the place for governments to begin.

Unfortunately, health promotion programs aimed at personal dietary choice and responsibility have limited impact in the face of massive advertising and marketing by the food and beverage industries. So far, despite health promotion in schools (reducing junk food and increasing physical activity) and other settings, the prevalence of obesity has remained stubbornly high. Industry self-regulation also sounds good, but the truth is, it doesn't work.

There clearly needs to be more effective action. But what actions will work?

The best available evidence and experience from other health risk behaviours (alcohol abuse, drunk driving, seat belt and helmet use, and smoking), shows that government action to "nudge" personal reduction in calorie consumption through regulation will most cost-effectively control the obesity epidemic. Here's how.

First, governments (federal, provincial) should introduce a substantial tax on sugar-sweetened beverages (SSBs). These beverages have little or no nutrient value and contribute significantly to excess calorie consumption. Although a few jurisdictions have applied small taxes to SSBs, there has not been an attempt to apply a substantial tax over a sufficient length of time to determine if this will reduce consumption. But economic theory, clinical evidence and experience from tobacco and alcohol suggest that this will not only reduce calorie consumption and obesity but also be a revenue source for government.

Second, governments (provincial, federal) should by regulation limit the marketing and sales of junk food and beverages, particularly to children. This should include controls on advertising through electronic and print media, sponsorship of sport, cultural, school-based and healthcare events and facilities as well as controls on the placement of junk food and beverages at check-outs and similar child targeted sites. At the municipal level this should be extended to control the availability of junk foods and beverages near schools.

Third, the federal government should implement a salt reduction strategy (including warning labels, advertising restrictions and procurement policies as in Bill C-460). Although salt in itself is not calorific, it is a key ingredient in the production of many junk foods — and often what keeps us coming back for more.

Fourth, governments needs to introduce a regulatory requirement for better calorie and nutrient information at the point of consumption in restaurants and other food outlets.

But wait: is this the dreaded "nanny statism" we've all been warned about?

In New York, when Mayor Bloomberg controlled the size of SSBs, he was accused of creating a "nanny state." But when the food and beverage industry makes large profits, leaving taxpayers to pick up the costs of providing healthcare for the victims of obesity-related disease, this is a failure of the market mechanism. It is governments' role to take corrective measures.

Yes, there may be some unintended consequences from such regulation — time will tell. But doing nothing is not an option.

Instead we should move forward now, but closely monitor and assess the results, learning from any mistakes and spreading success to other regions. To wait would be to lose the opportunity to make a real difference now — for us, and for future generations.

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Le gouvernement doit passer à l’action sur la question de l’obésité

D’abord, règlementer l’industrie des aliments et des boissons

JOHN MILLAR

Vous avez sûrement entendu dire que l’obésité a pris des proportions épidémiques au Canada et contribue à la hausse des troubles d’hypertension, de diabète, de maladies du cœur, d’AVC, de cancer et autres troubles de la santé. Mais peu est dit sur le fait que cette situation entraîne une hausse du coût des soins et met en péril la durabilité de notre système de santé financé par les fonds publics. L’épidémie d’obésité menace aussi la productivité de notre main-d’œuvre et réduit la compétitivité économique.

Ce dossier brûlant suscite peu de réaction de la part du gouvernement.

À la base, l’obésité est le résultat d’une consommation excessive de calories par opposition à la dépense de calories. Mais les causes et les solutions sont très complexes et incluent divers facteurs allant du taux de stress aux inégalités sociales, en passant par la production des aliments, la conception des villes et un éventail d’autres éléments dont la présence ne doit pas justifier l’inaction.

Le gouvernement doit tenir compte des nombreuses données probantes à ce sujet et poser des gestes concrets.

Donc, par où commencer? D'abord, réduire la consommation de calories. Bien que l'activité physique contribue au maintien d'une bonne santé, la recherche suggère que l'exercice seul ne suffit pas pour contrôler son poids. Ce n'est donc pas le premier élément sur lequel le gouvernement doit se pencher.

Malheureusement, les programmes de promotion de la santé axés sur la responsabilité et les choix alimentaires personnels ont un impact limité face aux grandes campagnes de publicité et de marketing menées par l'industrie des aliments et des boissons. À ce jour, malgré les efforts de promotion de la santé dans les écoles (réduire la malbouffe et augmenter l'activité physique) et d'autres lieux, le taux d'obésité demeure obstinément élevé. L'autoréglementation de l'industrie semble une voie invitante, mais dans les faits, cette approche ne fonctionne pas.

De toute évidence, des mesures plus efficaces sont nécessaires. Mais lesquelles?

Les meilleures données probantes et les expériences portant sur d'autres comportements à risque pour la santé (abus d'alcool, alcool au volant, non-utilisation de la ceinture de sécurité et du casque et tabagisme) démontrent que les mesures règlementaires que le gouvernement prendrait pour « pousser » les individus à réduire leur consommation de calories et contrer l'épidémie d'obésité s'avéreraient financièrement très rentables. Voici comment cela pourrait se faire.

Premièrement, les gouvernements (fédéral et provinciaux) doivent imposer une taxe importante sur les boissons contenant du sucre ajouté. Celles-ci ont peu sinon aucune valeur nutritive et représentent une part importante de la consommation excessive de calories. Bien que certaines juridictions aient imposé une modeste taxe sur ce type de boissons, il n'y a eu aucune tentative d'imposer une taxe substantielle sur une période suffisante pour déterminer si une telle mesure peut réduire la consommation. Toutefois, la théorie économique, les données cliniques et les apprentissages relatifs à la consommation de tabac et d'alcool suggèrent que cette mesure réduirait la consommation de calories et les taux d'obésité tout en générant un revenu pour les gouvernements.

Deuxièmement, les gouvernements (provinciaux et fédéral) doivent, par la voie de la règlementation, limiter le marketing et la vente d'aliments et de boissons vides, surtout aux enfants. Ces mesures incluraient un contrôle de la publicité électronique et imprimée, la commandite d'infrastructures et d'événements sportifs, culturels et scolaires, et des événements de promotion de la santé, ainsi qu'un contrôle sur les présentoirs d'aliments et de boissons vides aux caisses des épiceries et autres sites où circulent des enfants. À l'échelle municipale, ces mesures de contrôle doivent toucher aussi l'offre d'aliments et de boissons vides dans des lieux situés près des écoles.

Troisièmement, le gouvernement fédéral doit adopter une stratégie de réduction du sel (y compris des étiquettes de mise en garde, des politiques de restriction en matière de publicité et d'approvisionnement, comme le fait le projet de loi C-460). Le sel n'est pas calorifique en soi mais il constitue un ingrédient clé dans de nombreux aliments vides et suscite une envie soutenue de les consommer.

Quatrièmement, les gouvernements doivent introduire une règlementation qui oblige les restaurateurs et autres commerçants alimentaires à fournir une information plus complète sur le contenu calorifique et nutritif.

Mais attendez. Est-ce là l'« État hyperprotecteur » contre lequel on nous a tant mis en garde?

À New York, le maire Bloomberg, qui a règlementé le format des boissons contenant du sucre ajouté, a été accusé de mettre en place un « État hyperprotecteur ». Or, l'industrie des aliments et des boissons font d'énormes profits et refilent aux contribuables la facture pour les soins de santé

prodigués aux personnes atteintes de maladies liées à l'obésité. Cette situation confirme la faiblesse des mécanismes régissant le marketing et le gouvernement doit mettre en place des mesures correctives.

Oui, une telle réglementation pourrait entraîner des conséquences inattendues. Le temps le dira, mais l'inaction n'est pas une option.

Nous devons plutôt aller de l'avant en surveillant de près et en évaluant les résultats, en tirant des leçons des erreurs commises et en disséminant les réussites dans d'autres régions. Si nous attendons, nous perdrons une occasion de faire dès maintenant une réelle différence, pour nous et pour les générations à venir.

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It’s about time

Problem with fast food is more the “fast” than the “food”

Arya M. Sharma

If McDonalds took 30 minutes to serve you a hamburger, no one would eat there. If it took you 30 minutes to enjoy a Happy Meal, no one would bother. That same goes for any fast food restaurant.

Now let’s take the debate of whether a fast food meal is healthy or unhealthy out of the equation. Any calorically dense food that can be “inhaled” (bite and swallow — no chewing required!), will increase your likelihood of overeating.

In other words, the problem with fast food is more the “fast” than the “food.”

More importantly, “fast” is one of a cluster of cultural values that may not be good for our health — like it’s near cousin, “cheap.” It is not that fast food chains could not make a supremely healthy hamburger using the finest and leanest AAA beef, the choicest organically-grown lettuce, tomatoes and onions, lovingly placed between a whole grain, artisanal bun. It is just that they cannot make it for $3.50 and still expect to make a profit. This healthy and nutritious “gourmet” burger would likely cost $15, a price few consumers are willing to pay, even if they could afford it.

And then there’s “convenience.” It seems we are not cultured enough to know better than to eat at

our desks, in our cars, while on the phone, during meetings, or in front of our TVs — consuming food out of a cardboard box using nothing but our fingers.

The truth? We simply do not value healthy food enough to want to spend either the time, effort or money that healthy eating demands.

If we accept that healthy eating best consists of eating mostly home cooked meals prepared from fresh ingredients, eaten at a table, enjoyed mindfully with ample chewing (and don't forget to floss), we are looking at a minimum of 60 to 90 minutes a day devoted exclusively to eating. This recognizes that the "nourishment" we derive from healthy eating is as much a function of the nutritive value of foods as it is of the setting in which they are consumed.

Whether or not we value healthy eating enough to carve out 90 minutes from our already busy, time-starved schedules is the real question.

But time does not just limit our ability to eat healthy. It also limits our ability to be physically active. Most of us choose not to use active or public transportation, simply because driving our cars saves us time. We use power tools and household appliances simply because they get the job done quicker than the old fashioned way.

It is this need to save time and increase productivity that ultimately reduces our physical activity levels. Only seldom do we translate these time savings into time for exercise — more often than not, any time saved gets spent on even more sedentary activity.

Perhaps the most devastating impact of time starvation is when it cuts into our sleep. We live in a society that runs on caffeine — a sure sign of chronic sleep deprivation. Not only does sleep deprivation promote cravings for unhealthy foods, it also reduces our motivation and drive to be physically active — we are literally "exhausted."

This chronic lack of time also drives our stress levels leaving us anxious, guilty, irritable, frustrated and burnt-out under a dark cloud of impeding doom, thereby, laying a fertile field for emotional eating.

As I have yet to acquire a time-saving device that actually saves me time, I can see that there is no easy way out of this dilemma. Yes, there is always room for some increase in efficiencies and much is to be said for planning and prioritizing. Yet, whether we choose to reallocate our limited time to eating healthier, being more active and catching up on our sleep will ultimately determine whether or not we become healthier as individuals, as families and as a society.

The obesity epidemic is as much an epidemic of time starvation as it is of overconsumption. That the two are intimately linked is an uncomfortable truth that often gets lost in discussions that focus on simplistic "eat-less-move-more" solutions to addressing the obesity problem.

It may well be best to begin your journey to a healthier you by first tracking and questioning how you spend your time before tracking what you eat or how many steps you walk.

Dr. Arya M. Sharma, MD, is an expert adviser with EvidenceNetwork.ca, a professor, chair in obesity at the University of Alberta and scientific director of the Canadian Obesity Network.

(February 2013)

A version of this commentary appeared in *the Ottawa Citizen, iPolitics.ca* and the New Brunswick *Telegraph-Journal.*

Pay as you weigh an unfair pricing strategy

Playing a blame and shame game isn't a constructive solution to the obesity problem

Arya M. Sharma

This month, the wires were active with suggestions that people with obesity pay more for airline travel. This discussion was prompted by a Samoan airline announcing that they would begin charging passengers by the pound. It was also stimulated by Bharat Bhatta, an economist from Norway suggesting that heavier passengers pay a surcharge while lighter passengers are offered discounts.

The logical argument of course is that larger individuals take up more space and use up more jet fuel. This line of reasoning is sure to find ample supporters, as people who "choose" to be fat must clearly bear the consequences of their gluttony and sloth.

But why stop at airline travel? Here are some additional ideas for where businesses could charge larger individuals more:

Cab rides: This is not just to cover additional fuel costs but also to pay for wearing out the suspensions (assuming that these actually exist in cabs);

Hotel rooms: Not only will this cover the mattress surcharge but also cover the cost of the increased consumption of water, soap and extra towel required to "service" the greater body surface;

Gym memberships: To cover the additional wear and tear on the treadmills and other exercise equipment;

Amusement park rides: To pay for taking up more space, using more electricity and taking longer to load and off-load;

Ball games: For occupying an extra seat and obstructing the view.

Why not add all of these to the list of things that obese people are already paying more for, like health and life insurance, oversized clothing, bigger cars and sturdier home furniture?

That will certainly teach them to finally see the light and begin shedding those pounds.

But wait — did anyone mention that obesity rates are already markedly higher in poor income neighbourhoods, and that being obese already reduces an individual's chances of employment and promotion, despite ability?

The assumption underlying the "pay as you weigh" pricing strategies is that body size is a matter of choice and responsibility. Unfortunately, for most, this is not the case.

Let me state it clearly: Obesity is not simply a matter of laziness, overindulgence or lack of will power. It is a result of complex and diverse drivers of weight gain, including genetics, medications, stress, depression, addictions, eating, sleeping disorders and gut bugs — to name just a few.

The fact that obesity is far less under individual control than generally assumed is further evident from the fact that fewer than one in 20 individuals embarking on a weight loss attempt are likely to keep any of the weight off. The jury is still out on whether such failed attempts at weight loss are detrimental to health — they certainly are to the ego.

There could also be a number of unintended consequences of such a "pay as you weigh" policy, such as people starving themselves and abusing diuretics, laxatives and anorexic agents (including tobacco) to lose weight prior to boarding a flight. Such unhealthy weight-control practices are already widespread amongst competitive athletes who participate in sports that involve weight categories (e.g., boxers and wrestlers). This could be life threatening when it involves patients who are on medications for blood pressure or diabetes, where even short term attempts at weight loss can result in increase health risks, such as stroke and hypoglycaemic shock, for example.

A single emergency landing because of a diabetic patient skipping breakfast before weighing in for a flight would by far outweigh any potential savings to the airline (not to mention the inconvenience to other passengers).

Ultimately, however, it is a matter of fairness.

If airlines wish to treat their passengers like cargo, then a pay-as-you-weigh policy may appear justifiable. But if an airline sees itself as providing a service, namely, transporting human passengers, then the average price of a ticket (and the average size of a seat) should increase. This is the only fair distribution of costs, and the only fair way to accommodate everyone.

Playing a game of blame and shame is not a constructive solution to the obesity problem.

Dr. Arya M. Sharma, MD, is an expert adviser with EvidenceNetwork.ca, a professor, chair in obesity at the University of Alberta and scientific director of the Canadian Obesity Network.

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La tarification en fonction du poids est une mesure injuste

Le jeu de la culpabilisation n'est pas une solution constructive au problème de l'obésité

ARYA M. SHARMA

Cette semaine, on discutait fort dans les médias sur la question de savoir si les personnes atteintes d'obésité devraient payer leur billet d'avion plus cher que les autres passagers. C'est l'annonce d'un transporteur des îles Samoa qui a lancé le débat, ce dernier ayant décidé de fixer le prix des billets en fonction du poids. Bharat Bhatta, un économiste norvégien, a amené de l'eau au moulin en proposant pour sa part qu'on impose un supplément aux passagers les plus lourds et qu'on offre un rabais aux plus légers.

L'argument qui est mis de l'avant, c'est que les personnes de grande taille occupent plus de place que les autres et font grimper la consommation de carburant. Un raisonnement qui promet de récolter beaucoup d'appuis : il semble logique que les personnes qui « choisissent » d'être obèses assument les conséquences de leur gloutonnerie et de leur paresse.

Mais pourquoi s'arrêter aux déplacements en avion? Voici d'autres idées sur les moyens que pourraient prendre les entreprises pour facturer un supplément aux personnes de grande taille :

1. Courses en taxi : pour la surconsommation d'essence, mais aussi la détérioration des amortisseurs (pour autant que les taxis en soient réellement équipés);

2. Chambres d'hôtel : pour la surutilisation des matelas, mais aussi la quantité d'eau, de savon et de serviettes nécessaires à la toilette d'une surface corporelle étendue;

3. Abonnements au gym : pour l'usure des tapis roulants et de l'équipement;

4. Manèges des parcs d'attractions : pour le surplus d'espace et d'électricité, ainsi que le temps requis pour monter à bord et en sortir;

5. Parties de baseball : pour compenser le fait d'occuper un siège supplémentaire et d'obstruer la vue;

Pourquoi ne pas en effet ajouter ces éléments à la liste des extras que paient déjà les personnes obèses? Assurance-maladie et assurance-vie, vêtements adaptés, voitures de grandes dimensions, mobilier solidifié…

Voilà qui les incitera enfin à voir clair et à commencer à perdre ces kilos en trop.

Mais, un instant! Quelqu'un a-t-il pris la peine de souligner que les taux d'obésité sont sensiblement plus élevés dans les quartiers à faible revenu et que l'obésité diminue déjà les possibilités de trouver un emploi et d'obtenir une promotion, peu importe vos capacités?

Les mesures de tarification « au poids » supposent que la taille corporelle est une question de choix et de responsabilité. Malheureusement, ce n'est pas le cas pour la plupart des gens.

Laissez-moi l'affirmer sans détour : l'obésité n'est pas qu'une simple affaire de paresse, d'indulgence excessive ou de manque de volonté. Elle résulte d'un ensemble de facteurs complexes et diversifiés qui ont une incidence sur la prise de poids, dont la génétique, les médicaments, le stress, la dépression, les dépendances, les troubles de l'alimentation et du sommeil ainsi que les bactéries présentes dans le tube digestif — pour ne nommer que ceux-là.

Un autre fait vient confirmer l'idée que l'obésité est un phénomène sur lequel s'exerce un contrôle personnel largement inférieur à ce qu'on voudrait bien croire : moins d'une personne sur vingt qui suit un régime d'amaigrissement est susceptible de conserver la moindre perte de poids. On n'a pas encore déterminé hors de tout doute si ces échecs sont dommageables pour la santé, mais une chose est indéniable : ils le sont pour l'amourpropre.

Les politiques de tarification au poids pourraient avoir un certain nombre de conséquences imprévues; par exemple, la possibilité que des gens s'affament ou consomment une quantité excessive de diurétiques, de laxatifs ou d'agents anorexiques (dont le tabac) pour perdre du poids avant de monter à bord. De telles pratiques malsaines sont déjà courantes chez les athlètes de compétition qui pratiquent des sports comportant des catégories de poids (par ex., la boxe et la lutte). Elles pourraient mettre en danger la vie des patients qui prennent des médicaments pour contrôler la pression artérielle ou le diabète, des cas où la moindre tentative d'amaigrissement peut augmenter les risques pour la santé, notamment en ce qui concerne les accidents vasculaires cérébraux et les comas hypoglycémiques.

Un seul atterrissage d'urgence à cause d'un patient diabétique qui aurait décidé de sauter le petitdéjeuner en vue de la pesée pré-départ risque fort d'anéantir toute économie réalisée par le transporteur (sans parler du dérangement pour les autres passagers).

En dernière analyse, tout ceci est une question d'équité.

Si les transporteurs aériens décident de considérer leurs passagers comme une cargaison, alors une politique de tarification au poids pourra sembler justifiée. Par contre, si l'idée est de fournir un ser-

vice de transport à des êtres humains, c'est le prix moyen des billets (et la taille moyenne des sièges) qu'il faudrait hausser. C'est la seule façon de répartir équitablement les coûts et le seul moyen équitable d'offrir le service à l'ensemble de la clientèle.

Le jeu de la culpabilisation n'est pas une solution constructive au problème de l'obésité.

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Une version de ce commentaire est parue dans *le Huffington Post Québec* et *le Soleil*.

Appendix A

Absence of evidence is evidence of absence in health policy

Ernest Hoffman

This article originally appeared on J-Source.

By any objective measure, the Canadian public is awash in health information, and Canadian media outlets recognize the importance of public health issues. Whether it's the *Fifth Estate's* ongoing Rate My Hospital feature, the watered-down chemo controversy, or the recall of placebo birth control pills, health news is big news. Add to this the imminent expiration of the Canada Health Accord in 2014, and the federal government's recent decision to cut funding to the council that oversees it, and there's more than enough to sustain a healthy debate.

But is this debate well-informed? Does it make good use of available evidence?

One may argue that there remain significant barriers which impede academic research on health policy from reaching the public's awareness. Well-trained and highly-motivated journalists can be put off by the byzantine Canadian medical research structure. Blaming the journalist on a deadline for errors and omissions is easy, but it won't give them the judgment of a health policy expert. Could the research community itself contribute part of a solution?

A network of experts

Enter Dr. Noralou Roos, founder of the Evidence Network of Canadian Health Policy, an ambitious initiative to get the latest and best findings in health sciences and policy research into the broader public conversation by engaging the media. "I'm a traditional sort of researcher, and got into this business almost by accident," says Roos, Founding Director of the Manitoba Centre for Health Policy and one of the 100 most-cited scientists in Canada. "I've always thought academics should do a better job of communicating what they do to journalists."

Roos acknowledges that communication could be better on both sides. "Academics typically talk to other academics. We get promoted or recognized because we publish in places like the *Journal of the American Medical Association* or the *New England Journal of Medicine*," she says. "While journalists do follow those high-profile publications, they don't tend to follow health policy issues, which is what we were really interested in. How do you communicate these high-profile health policy issues to the media?"

A recent article in *Heathcare Policy* explains how Evidence Network established relationships with key health information partners — including the Canadian Health Services Research Foundation, Health Council of Canada, Canadian Institute of Health Information and Canadian Institutes of Health Research, among others — and built bridges between the research and journalistic communities.

Like Canada's approach to health, EvidenceNetwork.ca is now adapting in order to meet new challenges. What began in 2011 as a database with dozens of journalist-friendly experts on every facet of Canadian healthcare has evolved to take an even more active role in the journalistic process — publishing more Op-Eds, organizing events and harnessing social media.

Experts as commentators

In 2011, a meeting with comment editor Gerald Flood at the *Winnipeg Free Press* led to the first major

phase of Evidence Network's development. "I explained that we were trying to do and I asked him, 'How do we do this in an effective way?'" Flood suggested she work with Troy Media, a service that distributes commentaries of various kinds to Canadian media outlets large and small. Instead of waiting by their phones or inboxes for journalists' inquiries, Evidence Network's experts could now get their message directly into the country's newspapers.

This strategy proved very effective, with 146 different EvidenceNetwork.ca Op-Eds, letters and articles published 421 times in major media publications from April 2011 to the end of 2012. Counting niche, ethnic, online and community media, EN articles have been published well over 1000 times. Some of the most read, shared and commented EN articles from recent months include Michael Wolfson's look at how the Canadian healthcare system contributes to social equality, which ran in *the Globe and Mail*, and John Millar's call for government action on obesity, which ran in *the Toronto Star*. "I think editors start knowing who you are," says Roos. "Occasionally they'll call up and ask us if we have something on this or that, or they'll save something that we sent them and publish it two, three months later."

Earlier this year, these expert commentaries were grouped together by topic into an e-book, which was distributed free to the public in every major format. For a collection of health policy articles, the response from the public was surprisingly strong, even to Roos. "In Canada, 5000 sales is a bestseller," she says. "We've had almost 4200 reads of this e-book, which is great."

Evidence Network is now in the process of adding three new topic areas to the website: mental health, obesity and pharmaceutical policy. "These are topics which are frequently in the media," says Roos. "We've been talking with key individuals researching these issues, and they were keen to figure out how to communicate what they're doing."

Social media

Another area where Evidence Network has learned from journalists is the use of social media to reach a broader audience, including Twitter, YouTube, Facebook, Reddit, Pinterest and LinkedIn. "I'm trying to figure out how this new world works," says Roos. "We've been encouraging people to join the LinkedIn group because we do have discussions there, but there are a lot of academics who've never used LinkedIn, or Facebook, or any of this — so trying to persuade them that this is an important way of communicating is also challenging at times."

They've also begun to develop infographics as a way of communicating complex health issues such as spending, wait times, and changing habits in a simple way. The goal is to get the infographics shared across social networks and websites, sparking an interest in the issue which leads to a desire to learn more.

Policy impact

And it's not just the public that ends up learning something they didn't know. On more than one occasion, Evidence Network's articles have come to the awareness of policymakers, prompting them to reach back into the research community for more information that they weren't aware of. "One of our experts did an op-ed on the financial aspects of aging in *the Toronto Star*, and got a call the next day from the Federal Finance Committee that was meeting, and they wanted him to come and testify," says Roos.

Something similar happened in Manitoba while a major inquiry into the death of a child who was in care was underway. "I wanted to talk to the inquiry, to tell them to focus also on the broader issue

of why these kids in care are doing so poorly in general, in terms of educational outcomes, a whole series of things," she says. "And there was just no interest in anybody hearing from me about our research until one of our colleagues, Marni Brownell, wrote a commentary." The piece was published in several newspapers across Canada, including *the Winnipeg Free Press.*

The very next day, Brownell got a call from the inquiry to meet with them, and they ended up taking into account the broader context which the research represented. "When you can give examples like this, academics do become interested, because they realize that the media is a very powerful way of reaching people who can use evidence and research to make a difference in how things function."

Trudy Lieberman

Evidence Network is now preparing to focus on healthcare journalists. Trudy Lieberman, the immediate past president of the Association of Health Care Journalists, will be coming to Canada in the fall to meet with medical researchers and editorial boards in Montréal, Ottawa, Toronto, Winnipeg and Vancouver. She will also be studying the Evidence Network as a functioning model for her work on an international project which she's establishing.

"She's trying to set up a network of English-speaking healthcare journalists around the world, focusing on the issues which reporters need to know about, and who they talk to in different countries if they want more background on how this system works versus that system," says Roos. The visit is funded by the Fulbright Foundation and will include the Canadian Journalism Foundation and the Canadian Association of Journalists.

"[Lieberman's] developed a course on health policy reporting for American journalists, we're going to Canadianize it for Canadian journalists," says Roos. "And to put journalists in touch with Trudy, and these international individuals who are doing the same thing will also be very interesting."

Ernest Hoffman is currently an MA journalism student at Concordia University.

Making Evidence on Health Policy Issues Accessible to the Media

Noralou P. Roos, Kathleen O'Grady, Sharon Manson Singer, Shannon Turczak and Camilla Tapp

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Abstract

The media shape consumer expectations and interpretations of health interventions, influencing how people think about their need for care and the sustainability of the system. Evidence Network is a non-partisan, web-based project funded by the Canadian Institutes of Health Research and the Manitoba Health Research Council to make the latest evidence on controversial health policy issues available to the media. This website links journalists with health policy experts. We publish opinion pieces on current health policy issues in both French and English. We track who follows and uses the Evidence Network website and monitor the impact of our efforts.

Academics research important health policy issues, and journalists communicate with the public about these issues. Unfortunately, there is often a gap between what the media report and what researchers have found (Cohen 2009).

The media and academia are two different worlds. The media look for compelling personal stories and attention-grabbing headlines. Academics thrive on dry statistics and typically conclude that more research is needed. While a few academics become comfortable with the media, interactions with journalists are often unsatisfactory for researchers. Each side tends to come away discouraged and dismissive of the other.

Failing to communicate with the media, however, limits the exposure that research receives (Seeman 2009). Encouraging and training knowledgeable experts in the field to interact with the media is critical to the public's understanding of the evidence behind controversial health policy issues like the aging tsunami, the potential role of the private sector and wait times.

But being able and willing to talk to reporters and write opinion-editorial ("op-ed") pieces is no longer enough. Reporters actively use social media, particularly Twitter, to track breaking news; newspapers as well as radio and television stations have active websites with videos and webinars. Web-based media, such as the Huffington Post and popular blogs, also have a broad reach. Funding available through the Partnerships for Health System Improvement program of the Canadian Institutes for Health Research (CIHR) and the Manitoba Health Research Council (MHRC) have encouraged a group of academics to partner with media to sort out these issues. This initiative led to the launch of Evidence Network.

The Need for EvidenceNetwork.ca

To make it easy for the media to access evidence in covering key health policy issues, we have built a website that profiles evidence on controversial health policy topics. Journalists are also provided access to over 70 highly qualified experts to discuss these topics. Through workshops and introductions by means of our media partners, we have established links to journalists across the country. We

collaborate with key knowledge brokers of health policy evidence, including the Canadian Health Services Research Foundation, Health Council of Canada, Canadian Institute of Health Information, Canadian Institutes of Health Research and Canadian Agency for Drugs and Technology in Health. Evidence Network has already published more than 300 op-ed articles on a variety of health policy topics in newspapers across Canada. Our social media accounts, including Twitter, LinkedIn and Facebook, disseminate the evidence to reporters and others.

This integrated KT approach (CIHR 2012; Gagnon 2011) is designed to influence how evidence on key issues is transferred to the broader media and hence to the public and to decision-makers. Why focus on evidence? Because the public debate around health policy is important to Canadians (Gallagher 2005). An informed, non-partisan collaboration between healthcare researchers and the media enriches the public dialogue about current controversial health policy issues (Soroka and Fournier 2011). Canadians face ongoing decisions about many complex health policy issues, including the impact of an aging population, pharmaceutical spending, healthcare accessibility, private sector financing/delivery, user fees, sustainability of the healthcare system and inequality of access.

We seek to improve the Canadian healthcare system and, ultimately, the health of Canadians by ensuring that our best health policy evidence is understood by journalists and accurately communicated to Canadians and policy makers. Soroka (2007) has shown the power of public opinion in his graph tracking the relationship between healthcare spending and people's response to the question, "Do you think the federal government should spend more, spend less or spend the same amount on healthcare?" (Figure 1). When the public has concerns, healthcare spending tends to go up, even though the stories creating those concerns may have little basis in fact.

What Have We Done?

Evidence Network provides and promotes access to health policy experts and evidence. The website is designed to highlight a number of relevant and newsworthy health topics. Early conversations with journalists, including former and current publishers and editors, made it clear that neutrality was important. Several contacts mentioned that academics are known to be left-leaning; it was suggested that if all we wanted to do was provide a counter to the right-leaning Fraser Institute, then we would not be successful. The Canadian Centre for Policy Alternatives was noted to serve that function well.

Therefore, in putting together the evidence, we told our experts: "This project is about getting the evidence right; if there is anything missing, let us know. If we have gotten anything wrong, let us know and provide the evidence demonstrating this. We expect people will sometimes interpret the evidence differently. That is okay, but we do want to make sure we have the evidence right." We also hired a journalist to rewrite the material being put on the website and then checked with the experts to make sure the evidence had not been oversimplified. Overall, this was a challenging process.

Early on, we asked journalists to recommend the topics we should focus on and the types of evidence they needed. Their response was that they did not want to pick topics; rather, they placed importance on having quick and easy access to experts. We recruited experts using the criteria of the Science Media Centre of Canada (SMCC 2010), selecting highly regarded individuals with established academic reputations after review by other experts in the field. We reviewed their publishing record, ability to communicate in laypersons' language and the absence of partisan ties (including running for political office and lobbying affiliations). Some regional balance of experts is also sought. Experts are asked to respond to journalists within a two-hour time frame, if possible. They

also agreed to have their contact information placed on the website, including mobile numbers, and to provide a high-resolution photo of themselves.

Building on the Original Idea

Our original conception pretty much stopped here. However, we recruited a communications director (Kathleen O'Grady) who brought a wholly new set of ideas to the action plan. Owing to the changing media environment (Cooper and Brown 2010; Olson 2009), different forms of social media were needed to drive interest to the website. Journalists spend a lot of time on Twitter and are increasingly using it as a resource, so we implemented Twitter (2,200 followers and growing), as well as an invitation-only group on LinkedIn (118 members), Facebook, a YouTube video and a Wikipedia entry. Another key contribution was the suggestion that we could place op-ed pieces in mainstream media. Given that we were trying to get evidence into the media, what better way than to have our experts write the stories?

Op-ed writing is new for many academics (Dean 2009). It differs from academic publishing, and there would appear to be few rewards. However, this form of writing is an effective approach to knowledge translation and exchange (Heaselgrave and Morrison 2010). The receptivity at CIHR and from others to our success has been strong. O'Grady developed a set of guidelines for writing Op-Eds, working with our experts to revise their drafts (Figure 2).

The guidelines given to our experts consisted of the following points:

Your article should be 650–750 words.

Keep the wording simple; do not use jargon.

Express your opinion, and where possible, give personal examples.

Minimize statistics; avoid citations.

End with solutions and next steps (not just a recommendation for more research).

Because these Op-Eds are represented as products of Evidence Network, we also include an informal peer-review process. Noralou Roos sends Op-Eds that might raise red flags to other experts for critical appraisal before publication is sought.

While our communications director has done well at placing and reprinting Op-Eds with the high-profile newspapers (the *Toronto Star*, the *National Post*, the *Globe and Mail*, the *Huffington Post*, the *Hill Times*), we also work with Troy Media, a news service based in Calgary, to give our Op-Eds even further reach. Troy had been suggested by the comment editor of the *Winnipeg Free Press* when we were discussing how to make EvidenceNetwork.ca "work." Troy Media sends out Op-Eds in multiple waves to editors and media across the country, from the largest broadsheets to the smallest community newspapers. Material goes to opinion-page editors and talk shows, to health and lifestyle editors and reporters and to weekly news services.

Often, our op-ed articles are published with different titles (as editors have control over the title), half a dozen times on different days in papers small and large across the country. Since April 2011, our experts have published 81 Op-Eds more than 300 times in major media outlets, and several dozen more times in smaller community papers. As Figure 3 illustrates, the drafting and uptake of Op-Ed articles has not been uniform across all topics. The most widely published themes include healthcare costs and spending, and health as more than simply healthcare.

We are branching out beyond Op-Ed pieces into more mainstream articles for newspapers and magazines. Given that audio and video have been shown to be powerful communicators (Traphagan et al. 2010), we are posting videos of our experts on the website and have been encouraged to "shop" these to newspaper, radio and television. Initial interest is strong.

Success to Date

How successful have we been? One positive indicator is that the media are beginning to come to EvidenceNetwork.ca for material. *Macleans*, in their December 2011 article, "Why the Markets Can't Run Hospitals," quoted a description of how funding works in Canada, directly from our website: "According to the non-partisan Evidence Network website, out of the University of Manitoba, healthcare funding can be public, quasi-public and private … " (Belluz 2011).

The *Hill Times* – the Ottawa newspaper read by many in politics and the bureaucracy – asked us to submit Op-Eds to its special issue on health. Eight of 17 articles included in the online version of the *Hill Times* Policy Briefing: Health (February 6, 2012) were by EvidenceNetwork.ca experts. Others writing for this edition included the federal Minister of Health, Leona Aglukkaq, as well as MPs from the NDP, Liberal and Conservative parties. More mainstream outlets, like the *Huffington Post*, routinely ask for new content. Our publications have run in both French and English in nearly every Canadian newspaper, from *the Globe and Mail* to *the Sudbury Star*, from *le Devoir* to *le Soleil*.

We monitor usage of the website using Google Analytics. We communicate with our experts monthly on how many times they have spoken with the media, and we receive reports from Troy Media to track our performance.

According to Google Analytics:

The website has had well over 57,690 page views since May 2011 and almost 27,500 visits by 17,441 different readers. The number of page views continues to rise steadily.

Most visits came from people looking specifically by our URL, by our name or by direct referral to us compared to anonymous Google searches for key words, such as "health" or "medicare." This means we have good brand recognition. Because it takes time for Google to crawl through new sites to direct more traffic based on key words, we should expect future increases in traffic.

While we had visits from 106 different countries, the bulk of visits came from within Canada.

We had visits from 1,250 cities, with the top three cities being Winnipeg, Toronto and Ottawa.

While our most visited page is the landing page, other pages visited frequently are the page listing all our op-ed articles and that listing our experts.

A Google search to determine how many websites contain the phrase "evidencenetwork.ca" produced 11,300 results. Our outreach efforts appear to have been successful in persuading many others that we are a credible site to which to refer their readership. A search for our website URL, www.evidencenetwork.ca, identified 1,550 sites that hyperlink directly to the site. Our Twitter followers and re-tweeters include most top health reporters, MPs from all political parties, government ministers, NGOs, policy makers, medical students and others.

Troy Media monitors how frequently the media view our Op-Eds on the Troy site. Several times, one of our Op-Eds has been one of the most highly viewed articles. On June 17, 2012, Troy noted: "Gagnon and Sismondo's commentary, 'Beware the Ghosts of Medical Research,' has been read 6,701 times since yesterday. Congratulations; it was the top story on troymedia.com two days in a

row." Troy also reports every time one of our Op-Eds is published and provides circulation figures for that media outlet. For example, an op-ed by John Millar ran in the *Toronto Star* on March 14, 2012 (weekly circulation: 1,310,000). We track the total circulation exposure over time to assess the breadth of the audience reached.

Editors seem to like us because the Op-Eds are free and offer good material, and we provide the necessary details (photos, etc.). Editors, in turn, respond to our objections regarding headlines (that is the one thing they routinely write) and change them accordingly.

Conclusions

Are we unique? We are not sure. Several groups are working with the media. Science Media Centre of Canada (and similar centres in the United Kingdom and Australia) writes backgrounders on recently released scientific papers and offers links to pre-publication sources. However, these science media centres do not write Op-Eds and have traditionally covered the "one off" scientific breakthroughs. Health policy is a recurring issue that is more difficult to profile. Media Doctor (in Canada and the United States) and HealthNewsReview.org in the United States are also web-based groups; they independently review how the media report on drug issues.

Unique or not, our approach has lots to recommend it. We have recently received a three-year grant renewal from CIHR/MHRC that will enable us to expand our topics and build on previous efforts. More academic groups could adapt this model for working with the media to make research and evidence available to the public. There is little to lose, and the public is potentially the big winner.

Rendre accessible aux médias les données probantes sur les enjeux de politiques de santé

Résumé

Les médias façonnent les attentes et interprétations des consommateurs sur les interventions en santé, et ce, en influençant leur perception au sujet des besoins en matière de soins et au sujet de la durabilité du système. EvidenceNetwork.ca est un projet en ligne non partisan, fondé par les Instituts de recherche en santé du Canada et par le Conseil manitobain de la recherche en matière de santé. Ce projet vise à faciliter l'accès, pour les médias, aux données probantes récentes sur des enjeux controversés en matière de politiques de santé. Le site Web met en lien les journalistes et les spécialistes des politiques. Nous publions des articles d'opinion sur les enjeux de politiques de santé actuels, en français et en anglais. Nous étudions le profil des utilisateurs du site Web EvidenceNetwork.ca et nous surveillons l'impact de nos activités.

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Appendix B

2011–2013 Published Op-Eds Analyzed by Media Category

Months 2011	Op-Eds* Published per Month	Media Category A[1]	Media Category B[2]	Media Category C[3]	Media Category D[4]	Total Media Mentions
January	-	-	-	-	-	-
February	-	-	-	-	-	-
March	-	-	-	-	-	-
April	4	0	3	3	15	21
May	10	2	15	5	25	47
June	3	2	10	5	8	25
July	3	1	5	1	5	12
August	2	1	3	5	4	13
September	4	2	6	0	2	13
October	1	1	0	0	0	1
November	7	2	9	9	8	28
December	4	1	9	1	3	14
Total	38	12	60	29	70	171

*2 French Op-Eds were published in a major media (Le Devoir; Le Soleil; La Presse; Le Huffington Post Québec). These were included in the analysis. Ten "pending" Op-Eds were not included in the analysis.

Months 2012	Op-Eds* Published per Month	Media Category A[1]	Media Category B[2]	Media Category C[3]	Media Category D[4]	Total Media Mentions
January	6	1	5	0	5	11
February	16	3	26	3	23	55
March	6	3	6	4	7	20
April	3	0	6	4	6	16
May	9	2	14	10	14	40
June	7	3	9	5	11	28
July	13	6	25	10	22	63
August	6	2	11	15	20	48
September	12	3	18	3	8	32
October	6	0	8	7	12	27
November	6	3	16	9	12	40
December	9	3	10	16	11	40
Total	99	29	154	86	151	420

*18 French Op-Eds were published in a major media (Le Devoir; Le Soleil; La Presse; Le Huffington Post Québec). These were included in the analysis.

Months 2013	Op-Eds* Published per Month	Media Category A[1]	Media Category B[2]	Media Category C[3]	Media Category D[4]	Total Media Mentions
January	13	3	22	18	28	71
February	7	1	12	14	21	48
March	6	2	13	7	9	31
April	9	4	19	13	19	55
May	12	4	19	14	14	51
June	16	2	12	22	25	61
July	7	3	13	6	11	33
August	6	4	14	18	7	43
September	5	1	4	9	15	29
October	16	8	20	23	28	79
November	11	0	17	15	25	57
December	7	4	4	11	10	29
Total	115	36	169	170	212	587

*23 French Op-Eds were published in a major media (Le Devoir; Le Soleil; La Presse; Le Huffington Post Québec). These were included in the analysis.

[1] Globe and Mail
La Presse
Le Devoir
National Post
Toronto Star

[2] Calgary Herald
Calgary Sun
Halifax Chronicle Herald
Hill Times
Huffington Post
iPolitics
Le Huffington Post Quebec
Le Soleil

Montreal Gazette
Ottawa Citizen
Ottawa Sun
Vancouver Sun
Winnipeg Free Press
Winnipeg Sun

[3] Charlottetown Guardian
Edmonton Journal
Guelph Mercury
Hamilton Spectator
Kingston Whig Standard
Le Droit
Leader-Times
Medical Post
New Brunswick Telegraph
NB Times and Transcript
Ottawa Life
Saskatchewan Star Phoenix
St. John's Times and Telegraph
Sudbury Star
Toronto Sun
Vancouver Province
Victoria Times Colonist
Waterloo Region Record
Windsor Star

[4] Any other media not listed above

About the Editors

Noralou Roos

Noralou P. Roos received her PhD from the Massachusetts Institute of Technology in 1968. In 1972 she received the SearsRoebuck Foundation Federal Faculty Fellow, and moved to the University of Manitoba in 1973. She joined the Population Health Group at the Canadian Institute for Advanced Research in 1988. Noralou was a co-Founder of the Manitoba Centre for Health Policy. She headed the group which received Canadian Foundation for Innovation funding to create Canada's first data laboratory, containing population based data on health, education and social services and held a Tier 1 Canada Research Chair. Citations to Dr. Roos' work place her among the top 100 Canadian scientists according to The Institute of Scientific Information.

She was a member of the Prime Minister's National Forum on Health, the Interim Governing Council setting up the Canadian Institutes for Health Research (CIHR), received the Order of Canada in 2005, was elected a member of the Academy of Sciences of the Royal Society of Canada (2009), and most recently received a Fellowship in the Canadian Academy of Health Sciences. Noralou led the Canadian Drug Policy Development Coalition working with Health Canada and the provinces which resulted in the funding of the Drug Safety and Effectiveness Network (DSEN) at CIHR. She has also been working with community groups, business and government to bring research on "At-Risk" kids to the policy table. She is a Member of the United Way of Winnipeg Board of Trustees. Dr. Roos received the Inaugural Population and Public Health Research Milestone Award, CIHR and CPHA, and in 2010, gave the Emmett Hall Memorial Lecture, one of Canada's most prestigious lectureships, which commemorates the father of Canadian Medicare, with an annual address at the Canadian Association for Health Services and Policy Research Conference.

Kathleen O'Grady

Kathleen O'Grady is a Research Associate at the Simone de Beauvoir Institute, Concordia University and the author and editor of numerous books and articles on health, women's and cultural issues. She is also the Founding Director of QUOI Media Group, specializing in political, policy and media research and strategy consulting. She has written and edited speeches, Op-Eds, policy briefs and research papers for Senators, MPs, MPPs, Chiefs of Police, academics and CEOs. Her client list includes the Senate of Canada, a number of Ottawa-based think tanks, universities, politicians, artists and authors, and a wide range of national non-profit organizations.

In this capacity, she works as the Director of Communications and the Managing Editor for EvidenceNetwork.ca. On behalf of the research network she strategizes and edits the Op-Ed content from a wide-range of academic experts and works with editors at Canada's leading newspapers to make these submissions ready for publication. She also oversees a small communications team that actively pushes these commentaries, and other related projects, such as videos, backgrounders, webinars and infographics, through popular social media channels to raise the level of evidence in popular discourse about Canadian health policy options.

Kathleen is also a volunteer editor with Wikipedia on the Canada Project and she is on the board of directors for Girls Action Foundation/Fondation filles d'action. She lives in Ottawa, Canada with her family, and is the mother of two young boys, one with autism.

Shannon Turczak

Shannon Turczak is both the webmaster and e-newsletter editor for EvidenceNetwork.ca, in addition to providing administrative and executive support to the Director and the Director of Communications. She manages the day-to-day operations of EvidenceNetwork.ca and participates in the strategic direction of the project through team meetings.

Camilla Tapp

Camilla Tapp has been a research assistant with EvidenceNetwork.ca since May 2012. She was heavily involved in the development of *Canadian Healthy Policy in the News: Why Evidence Matters*, and provides support to the daily operation of EvidenceNetwork.ca. Camilla is also an MBA student at McMaster University in the DeGroote School of Business, focusing in Health Services Management.

Lindsay Jolivet

Lindsay Jolivet holds a Bachelor of English from McMaster University and a Master of Journalism from Carleton University. She completed a health policy journalism internship with EvidenceNetwork.ca in 2012 and she's since worked as a writer, proofreader and communications professional for organizations including *Yahoo! Canada News*, the *Literary Review of Canada* and Fogo Island Arts. In December, she began a new position as Writer & Media Relations Specialist at the Canadian Institute for Advanced Research.